

J U N E 2 0 1 2

A DATA BOOK

Health Care Spending
and the
Medicare Program

MEDPAC Medicare
Payment Advisory
Commission

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Introduction

MedPAC's Data Book is the result of discussions with congressional staff members regarding ways that MedPAC can better support them. Some of the information it contains is derived from MedPAC's March and June reports to the Congress; other information presented is unique to the Data Book. The format is condensed into tables and figures with brief discussions. Website links to MedPAC publications and other websites are included on a "Web links" page at the end of each section.

The Data Book provides information on national health care and Medicare spending, as well as Medicare beneficiary demographics, dual-eligible beneficiaries, quality of care in the Medicare program, and Medicare beneficiary and other payer liability. It also examines provider settings—such as hospitals and post-acute care—and presents data on Medicare spending, beneficiaries' access to care in the setting (measured by the number of beneficiaries using the service, number of providers, volume of services, length of stay, or through direct surveys), and the sector's Medicare profit margins, if applicable. In addition, it covers the Medicare Advantage program and prescription drug coverage for Medicare beneficiaries, including Part D.

Several charts in this Data Book use data from the Medicare Current Beneficiary Survey (MCBS). We use the MCBS to compare beneficiary groups with different characteristics. The MCBS is a survey, so expenditure amounts that we show may not match actual Medicare expenditure amounts from CMS's program offices or the Office of the Actuary.

Changes in aggregate spending among the fee-for-service sectors presented in this Data Book reflect changes in Medicare enrollment between the traditional fee-for-service program and Medicare Advantage. Increased enrollment in Medicare Advantage may be a significant factor in instances in which Medicare spending in a given sector has leveled off or even declined. In these instances, fee-for-service spending per capita may present a more complete picture of spending changes.

We produce a limited number of printed copies of this report. It is, however, available through the MedPAC website: www.medpac.gov.

Table of contents

Introduction	iii
---------------------------	------------

Sections

1	National health care and Medicare spending	1
1-1	Aggregate Medicare spending among FFS beneficiaries, by sector, 2000–2010	3
1-2	Per capita Medicare spending among FFS beneficiaries, by sector, 2000–2010	4
1-3	Medicare made up over one-fifth of spending on personal health care in 2010.....	5
1-4	Medicare’s share of total spending varies by type of service, 2010	6
1-5	Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding	7
1-6	Trustees project Medicare spending to increase as a share of GDP	8
1-7	Changes in spending per enrollee, Medicare and private health insurance	9
1-8	Trustees and CBO project Medicare spending to grow at an annual average rate of around 6 percent over the next 10 years	10
1-9	Medicare spending is concentrated in certain services and has shifted over time.....	11
1-10	FFS program spending is highly concentrated in a small group of beneficiaries, 2008	12
1-11	Medicare HI trust fund is projected to be insolvent in 2024 under actuaries’ intermediate assumptions	13
1-12	Medicare faces serious challenges with long-term financing	14
1-13	Average monthly SMI premiums and cost sharing are projected to grow faster than the average monthly Social Security benefit	15
1-14	Medicare HI and SMI program payments and cost sharing per beneficiary in 2010.....	16
	Web links	17
2	Medicare beneficiary demographics	19
2-1	Aged beneficiaries account for the greatest share of the Medicare population and program spending, 2008.....	21
2-2	Medicare enrollment and spending by age group, 2008	22
2-3	Beneficiaries who report being in poor health account for a disproportionate share of Medicare spending, 2008	23
2-4	Enrollment in the Medicare program is projected to grow rapidly in the next 20 years	24
2-5	Characteristics of the Medicare population, 2008	25
	Web links	26
3	Dual-eligible beneficiaries	27
3-1	Dual-eligible beneficiaries account for a disproportionate share of Medicare spending, 2008	29
3-2	Dual-eligible beneficiaries are more likely than non-dual eligibles to be disabled, 2008.....	30
3-3	Dual-eligible beneficiaries are more likely than non-dual eligibles to report poorer health status, 2008.....	31

3-4	Demographic differences between dual-eligible beneficiaries and non-dual eligibles, 2008	32
3-5	Differences in spending and service use rate between dual-eligible beneficiaries and non-dual eligibles, 2008	33
3-6	Both Medicare and total spending are concentrated among dual-eligible beneficiaries, 2008	34
	Web links	35
4	Quality of care in the Medicare program	37
4-1	In-hospital and 30-day post-discharge mortality rates improved from 2007 to 2010	39
4-2	Hospital inpatient patient safety indicators improved or were stable from 2007 to 2010	40
4-3	Risk-adjusted SNF quality measures show mixed results since 2000	41
4-4	Home health quality measures show limited change in 2011	42
4-5	Dialysis quality of care: Some measures show progress, others need improvement	43
4-6	Medicare Advantage quality measures show improvement between 2010 and 2011	44
	Web links	46
5	Medicare beneficiary and other payer financial liability	49
5-1	Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2009	51
5-2	Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2009	52
5-3	Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2009	53
5-4	Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2009	54
5-5	Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2009	55
5-6	Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2009	56
	Web links	57
6	Acute inpatient services	59
	Short-term hospitals	
6-1	Annual changes in number of acute care hospitals participating in the Medicare program, 2000–2010	61
6-2	Percent change in hospital employment, by occupation, 2008–2010	62
6-3	Growth in Medicare's FFS payments for hospital inpatient and outpatient services, 1999–2010	63
6-4	Proportion of Medicare acute care hospital inpatient discharges by hospital group, 2010	64
6-5	Major diagnostic categories with highest volume, fiscal year 2010	65
6-6	Cumulative change in total admissions and total outpatient visits, 1999–2010	66
6-7	Cumulative change in Medicare outpatient services and inpatient discharges per FFS beneficiary, 2004–2010	67
6-8	Trends in Medicare inpatient and non-Medicare inpatient length of stay, 1999–2010	68
6-9	Share of inpatient admissions preceded by emergency department visit, 2005–2010	69

6-10	Share of Medicare Part A beneficiaries with at least one hospitalization, 2000–2010	70
6-11	Hospital occupancy rates, 1999–2010	71
6-12	Medicare inpatient payments, by source and hospital group, 2010	72
6-13	Medicare acute inpatient PPS margin, 1999–2010	73
6-14	Medicare acute inpatient PPS margin, by urban and rural location, 1999–2010	74
6-15	Overall Medicare margin, 1999–2010	75
6-16	Overall Medicare margin, by urban and rural location, 1999–2010	76
6-17	Hospital total all-payer margin, 1999–2010	77
6-18	Hospital total all-payer margin, by urban and rural location, 1999–2010	78
6-19	Hospital total all-payer margin, by teaching status, 1999–2010	79
6-20	Medicare margins by teaching and disproportionate share status, 2010	80
6-21	Financial pressure leads to lower costs	81
6-22	Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1987–2010	82
6-23	Markup of charges over costs for Medicare services, 1999–2010	83
6-24	Number of critical access hospitals, 1999–2012	84
	Specialty psychiatric facilities	
6-25	Medicare payments to inpatient psychiatric facilities, 2002–2011	85
6-26	Number of inpatient psychiatric facility cases has fallen under the PPS, 2002–2009	86
6-27	Inpatient psychiatric facilities, 2003–2009	87
6-28	One diagnosis accounted for almost three-quarters of IPF cases in 2009	88
6-29	IPF discharges by beneficiary characteristics, 2009	89
	Web links	90
7	Ambulatory care	91
	Physicians	
7-1	Medicare spending per FFS beneficiary on physician fee-schedule services, 2001–2011	93
7-2	Volume growth has raised physician spending more than input prices and payment updates, 2000–2010	94
7-3	Most beneficiaries report that they can always or usually get timely care, 2011	95
7-4	Medicare beneficiaries report better ability to get timely appointments with physicians, compared with privately insured individuals, 2008–2011	96
7-5	Medicare and privately insured patients who are looking for a new physician report more difficulty finding one in primary care, 2008–2011	97
7-6	Access to physician care is better for Medicare beneficiaries compared with privately insured individuals, but minorities in both groups report problems more frequently, 2011	98
7-7	Differences in access to new physicians are most apparent among minority Medicare and privately insured patients who are looking for a new specialist, 2011	99
7-8	Growth in volume of physician fee schedule services per beneficiary, 2000–2010	100
7-9	Changes in physicians' professional liability insurance premiums, 2004–2011	101
	Hospital outpatient services	
7-10	Spending on all hospital outpatient services, 2001–2011	102
7-11	Most hospitals provide outpatient services	103
7-12	Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2010	104

7-13	Hospital outpatient services with the highest Medicare expenditures, 2010	105
7-14	Medicare coinsurance rates, by type of hospital outpatient service, 2010.....	106
7-15	Effects of hold-harmless and SCH transfer payments on hospitals’ outpatient revenue, 2008–2010	107
7-16	Medicare hospital outpatient, inpatient, and overall Medicare margins, 2004–2010.....	108
7-17	Number of observation hours has increased, 2006–2010	109
	Ambulatory surgical centers	
7-18	Number of Medicare-certified ASCs increased by 33 percent, 2004–2011	110
	Imaging services	
7-19	Medicare spending for imaging services under the physician fee schedule, by type of service, 2010.....	111
7-20	Rapid growth in the number of CT and MRI scans per 1,000 beneficiaries, 2000–2010	112
	Web links	113
8	Post-acute care	115
8-1	Number of post-acute care providers increased or remained stable in 2011	117
8-2	Medicare’s spending on home health care and skilled nursing facilities fueled growth in post-acute care expenditures	118
	Skilled nursing facilities	
8-3	Since 2006, the share of Medicare stays and payments going to freestanding SNFs and for-profit SNFs has increased.....	119
8-4	Small declines in SNF days and admissions between 2009 and 2010	120
8-5	Case mix in freestanding SNFs shifted toward highest rehabilitation case-mix groups and away from other categories	121
8-6	Freestanding SNF Medicare margins have exceeded 10 percent for seven years, and have increased steadily since 2005	122
8-7	Freestanding SNFs with relatively low costs and relatively high quality maintained high Medicare margins.....	123
	Home health agencies	
8-8	Spending for home health care, 1997–2011	124
8-9	Provision of home health care changed after the prospective payment system started.....	125
8-10	Trends in provision of home health care	126
8-11	Margins for freestanding home health agencies	127
	Inpatient rehabilitation facilities	
8-12	Most common types of inpatient rehabilitation facility cases, 2011	128
8-13	Volume of IRF FFS patients declined slightly in 2010.....	129
8-14	Overall IRFs’ payments per case have risen faster than costs since implementation of the PPS in 2002	130
8-15	Inpatient rehabilitation facilities’ Medicare margin by type, 2002–2010.....	131

Long-term care hospitals	
8-16	The top 25 MS-LTC-DRGs made up nearly two-thirds of LTCH discharges in 2010 132
8-17	LTCH spending per FFS beneficiary continues to rise 133
8-18	LTCHs' per case payments rose more quickly than costs in 2010 134
8-19	LTCHs' aggregate Medicare margin rose in 2010 135
8-20	LTCHs in the top quartile of Medicare margins in 2010 had much lower costs..... 136
	Web links 137
9	Medicare Advantage 139
9-1	MA plans available to virtually all Medicare beneficiaries 141
9-2	Access to zero-premium plans with MA drug coverage, 2006–2012..... 142
9-3	Enrollment in MA plans, 1994–2012 143
9-4	Changes in enrollment vary among major plan types 144
9-5	MA and cost plan enrollment by state and type of plan, 2012..... 145
9-6	MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2012 ... 146
9-7	Enrollment in employer group MA plans, 2006–2012 147
9-8	Number of special needs plan enrollees, 2007–2012 148
9-9	Number of SNPs and SNP enrollment rose from 2011 to 2012 149
9-10	Twenty most common condition categories among MA beneficiaries, defined in the CMS–HCC model, 2008 150
9-11	Distribution of MA plans and enrollment by CMS overall star ratings, April 2012..... 151
	Web links 153
10	Prescription drugs 155
10-1	Medicare spending for Part B drugs administered in physicians' offices or furnished by suppliers 157
10-2	Top 10 Part B drugs administered in physicians' offices or furnished by suppliers, by share of expenditures, 2010..... 158
10-3	In 2010, about 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage 159
10-4	Parameters of the defined standard benefit increase over time 161
10-5	Characteristics of Medicare PDPs 162
10-6	Characteristics of MA–PDs 163
10-7	Average Part D premiums..... 164
10-8	Number of PDPs qualifying as premium-free to LIS enrollees remained stable in 2012 165
10-9	In 2012, most Part D enrollees are in plans that charge higher copayments for nonpreferred brand-name drugs 166
10-10	In 2012, use of utilization management tools continues to increase for both PDPs and MA–PDs... 167
10-11	Characteristics of Part D enrollees, 2010..... 168
10-12	Part D enrollment trends, 2006–2010 170
10-13	Part D enrollment by region, 2010..... 171
10-14	The majority of Part D spending is incurred by fewer than half of all Part D enrollees, 2010..... 173
10-15	Characteristics of Part D enrollees, by spending levels, 2010 174
10-16	Part D spending and utilization per enrollee, 2010..... 175

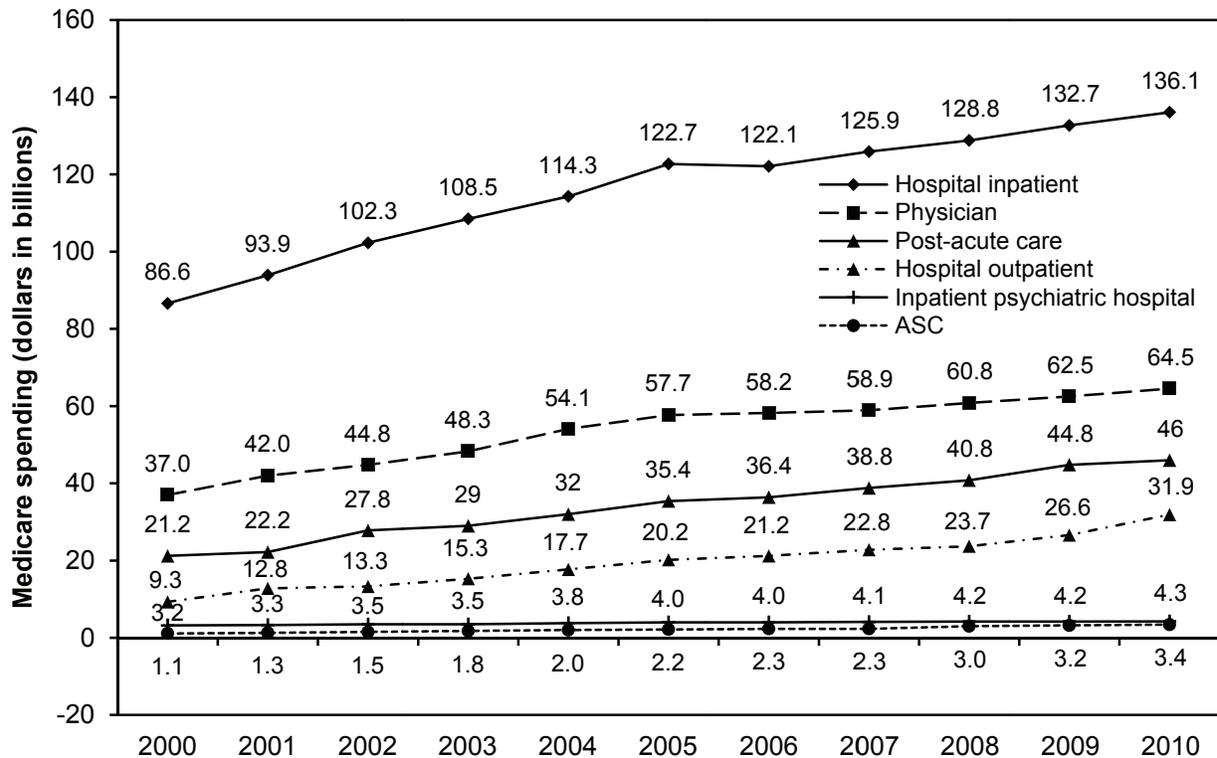
10-17	Part D risk scores vary across regions, by plan type and by LIS status, 2010.....	176
10-18	Top 15 therapeutic classes of drugs under Part D, by spending and volume, 2010.....	178
10-19	Generic dispensing rate for the top 15 therapeutic classes, by plan type, 2010.....	179
10-20	Generic dispensing rate for the top 15 therapeutic classes, by LIS status, 2010.....	180
	Web links.....	181
11	Other services.....	183
	Dialysis	
11-1	Number of dialysis facilities is growing and share of for-profit and freestanding dialysis providers is increasing.....	185
11-2	Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2005 and 2010.....	186
11-3	Dialysis facilities' capacity increased between 2006 and 2010.....	187
11-4	Characteristics of Medicare fee-for-service dialysis patients, 2010.....	188
11-5	The ESRD population is growing, and most ESRD patients undergo dialysis.....	189
11-6	Diabetics, middle-aged and the elderly, Asian Americans, and Hispanics are among the fastest growing segments of the ESRD population.....	190
11-7	Aggregate margins vary by type of freestanding dialysis facility, 2010.....	191
	Hospice	
11-8	Medicare hospice use and spending grew substantially from 2000 to 2010.....	192
11-9	Hospice use increased across beneficiary groups from 2000 to 2010.....	193
11-10	Number of Medicare-participating hospices has increased, largely driven by for-profit hospices....	194
11-11	Hospice cases and length of stay, by diagnosis, 2009.....	195
11-12	Long hospice stays are getting longer, while short stays remain virtually unchanged, 2000 and 2010.....	196
11-13	Hospice average length of stay among decedents, by beneficiary and hospice characteristics, 2009.....	197
11-14	Hospice aggregate Medicare margins, 2003–2009.....	198
11-15	Medicare margins are higher among hospices with more long stays, 2009.....	199
11-16	Hospices that exceeded Medicare's annual payment cap, selected years.....	200
11-17	Length-of-stay and live discharge rates for above- and below-cap hospices, 2009.....	201
11-18	Margins are higher among hospices with a greater share of their patients in nursing facilities, 2009.....	202
	Clinical laboratory	
11-19	Medicare spending for clinical laboratory services, 2002–2011.....	203
	Web links.....	204

SECTION

1

**National health care and
Medicare spending**

Chart 1-1. Aggregate Medicare spending among FFS beneficiaries, by sector, 2000–2010

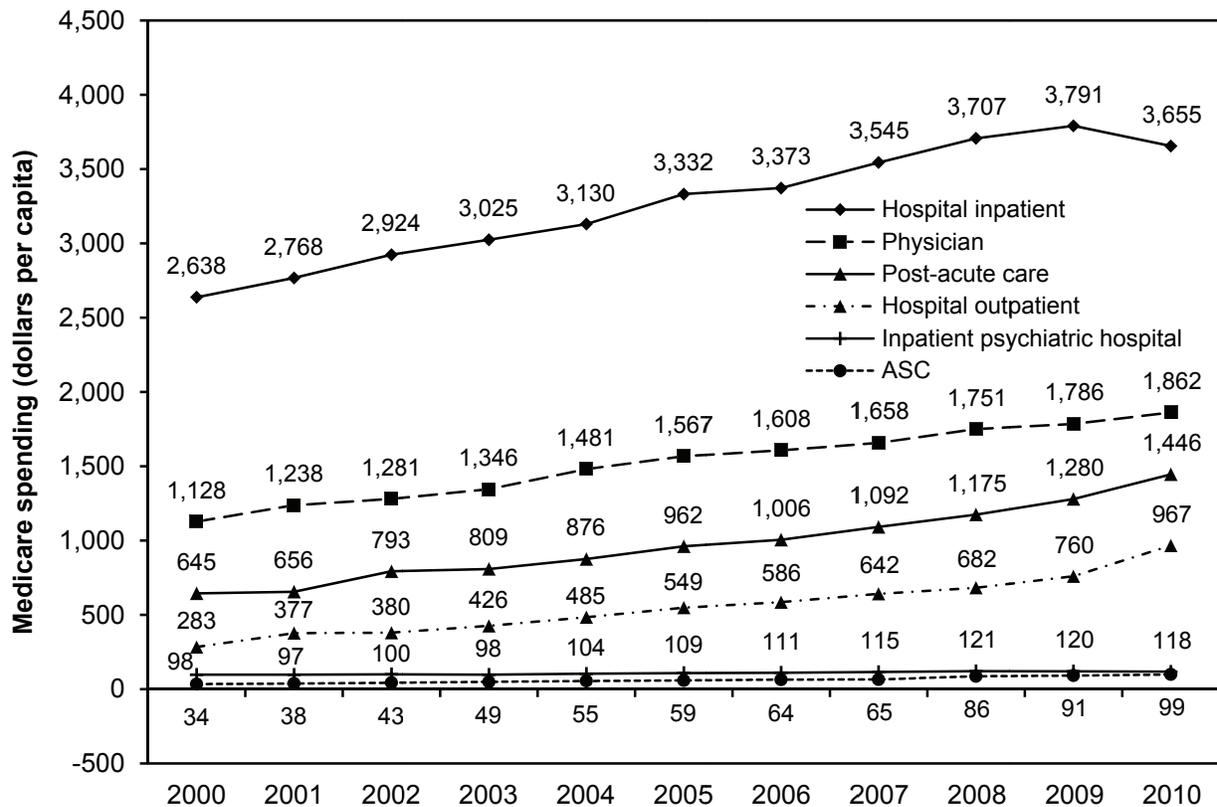


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is not included in these aggregate totals.

Source: CMS Office of the Actuary and the 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending among FFS beneficiaries grew strongly in most sectors from 2000 through 2004. Spending growth slowed slightly from 2005 to 2007, rebounding briefly in 2008 and 2009, then moderating in 2010. The slowing in aggregate spending from 2005 to 2007 is partially attributable to a decline in the number of FFS beneficiaries as the number of Medicare Advantage enrollees increased.

Chart 1-2. Per capita Medicare spending among FFS beneficiaries, by sector, 2000–2010

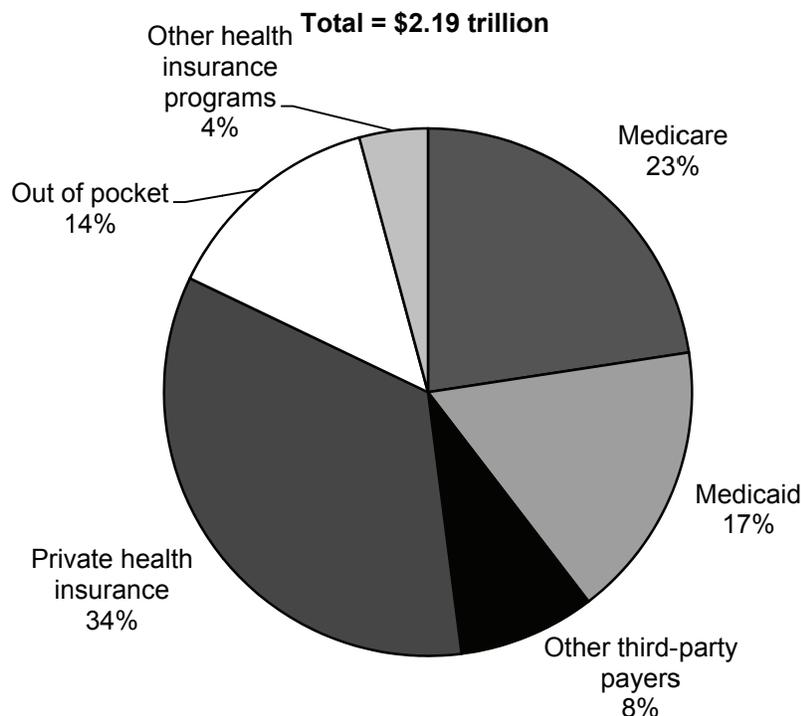


Note: FFS (fee-for-service), ASC (ambulatory surgical center). Dollars are Medicare spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary and the 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending per beneficiary in FFS Medicare increased steadily in most sectors from 2000 through 2009, with some sectors slowing in 2010.

Chart 1-3. Medicare made up over one-fifth of spending on personal health care in 2010

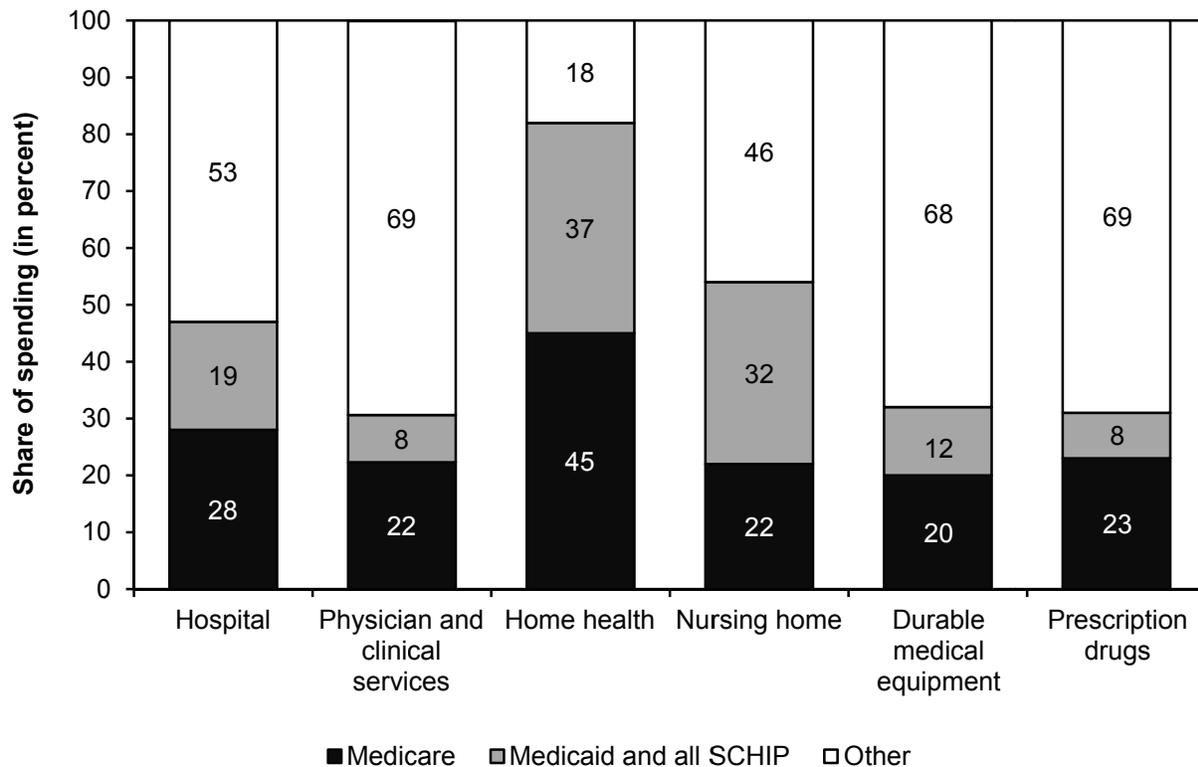


Note: Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Premiums are included with each program (e.g., Medicare, private insurance) rather than in the out-of-pocket category. Other health insurance programs include the Children's Health Insurance Program, Department of Defense, and Department of Veterans' Affairs. Other third-party payers include worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2012.

- Of the \$2.19 trillion spent on personal health care in the United States in 2010, Medicare accounted for 23 percent, or \$525 billion (as noted above, this amount includes direct patient care spending and excludes certain administrative and business costs). Medicare is the largest single purchaser of health care in the United States. Thirty-four percent of spending was financed through private health insurance payers and 14 percent was from consumer out-of-pocket spending.
- Medicare and private health insurance spending include premium contributions from enrollees.

Chart 1-4. Medicare’s share of total spending varies by type of service, 2010

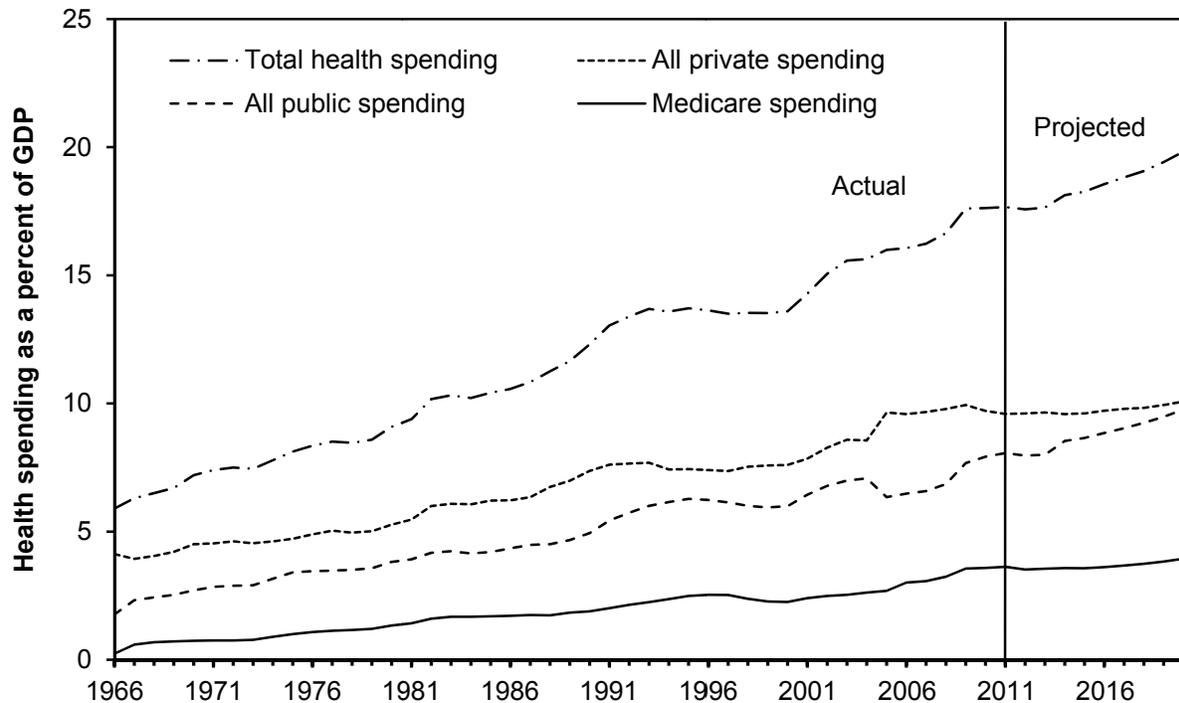


Note: SCHIP (State Children’s Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 percent due to rounding. “Other” includes private health insurance, out-of-pocket spending, and other private and public spending.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2012.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population and does not cover services such as long-term care.
- In 2010, Medicare accounted for 28 percent of spending on hospital care, 22 percent of physician and clinical services, 45 percent of home health services, 22 percent of nursing home care, 20 percent of durable medical equipment, and 23 percent of prescription drugs.

Chart 1-5. Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding

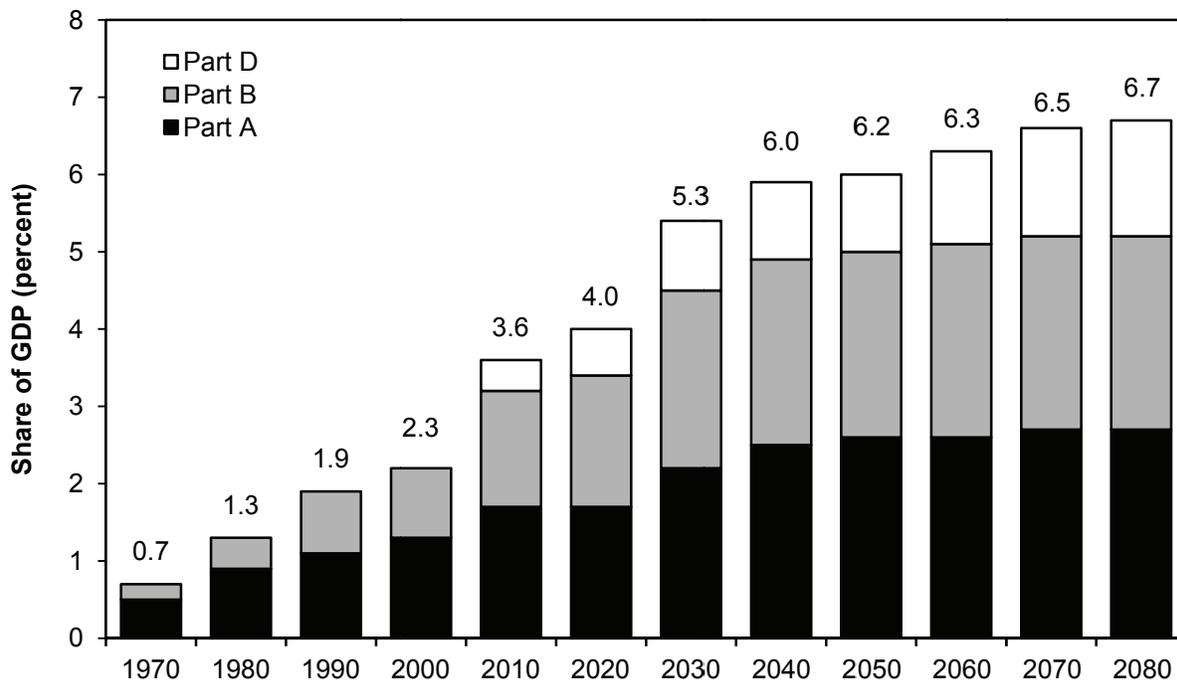


Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2012.

- Total health spending consumes an increasing proportion of national resources, accounting for a double-digit share of GDP annually since 1982.
- As a share of GDP, total health spending has increased from about 6 percent in 1965 to about 18 percent in 2010, and is projected to reach 20 percent of GDP in 2020. Health spending's share of GDP was stable throughout much of the 1990s due to slower spending growth associated with greater use of managed care techniques and higher enrollment in managed plans, as well as a strong economy.
- Medicare spending has also grown as a share of the economy from less than 1 percent when it was started in 1965 to about 3.6 percent today. Projections suggest that Medicare spending will make up 4 percent of GDP by 2020.
- In 2010, all public spending made up about 45 percent of total health care spending and private spending made up 55 percent. By 2020, those percentages are projected to be 49 percent and 51 percent, respectively.

Chart 1-6. Trustees project Medicare spending to increase as a share of GDP

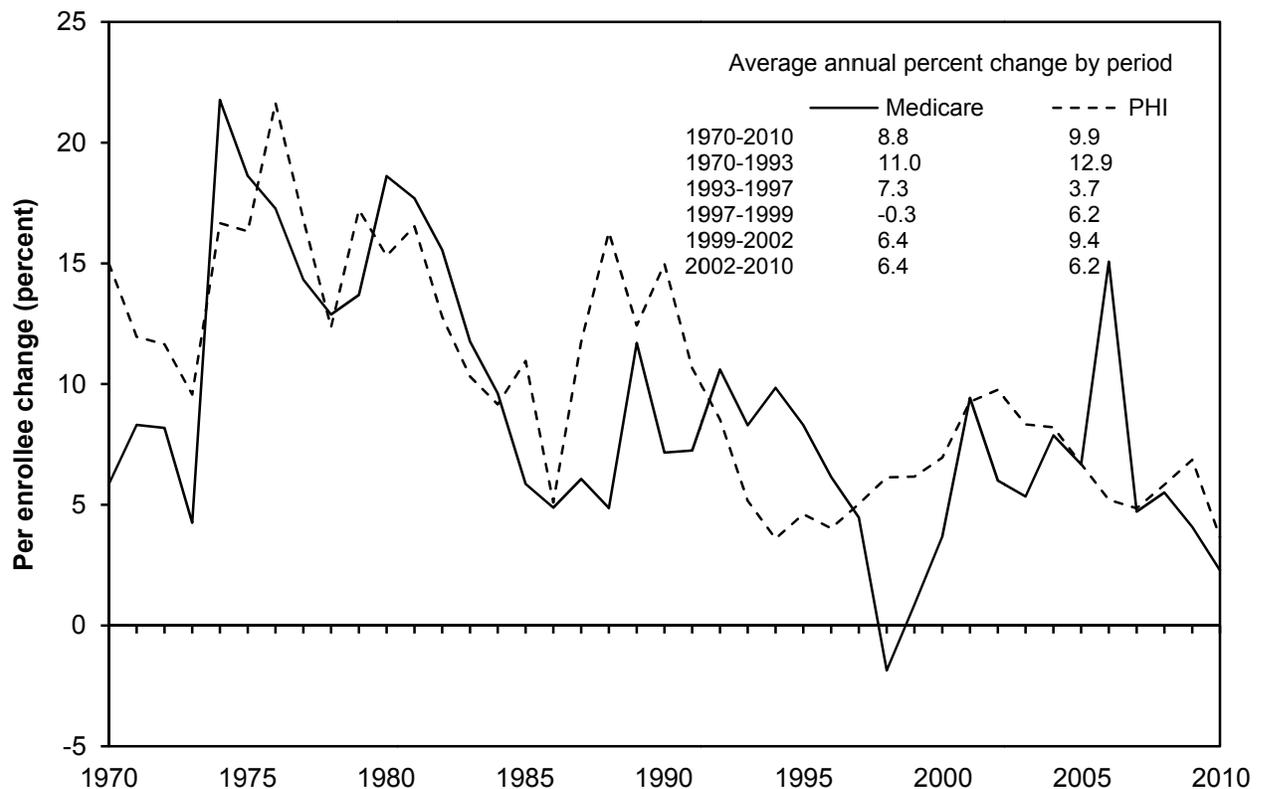


Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Over time, Medicare spending has accounted for an increasing share of GDP. From less than 1 percent in 1970, it is projected to reach 6.7 percent of GDP in 2080.
- Nominal Medicare spending grew on average 9.1 percent per year over the period from 1980 to 2010, considerably faster than nominal growth in the economy, which averaged 5.7 percent per year over the same time frame. Future Medicare spending is projected to continue growing faster than GDP, averaging 5.5 percent per year between 2010 and 2080 compared with an annual average growth rate of 4.6 percent for the economy as a whole. In other words, Medicare spending is projected to continue rising as a share of GDP, but at a slower pace. Medicare's share of GDP is projected to reach 6.7 percent in 2080.
- Beginning in 2010, the aging of the baby-boom generation, an expected increase in life expectancy, and the Medicare drug benefit are likely to increase the proportion of economic resources devoted to Medicare, growing from 3.6 percent of GDP in 2010 to 6.0 percent of GDP by 2040. Additional factors, such as innovation in medical technology and the widespread use of insurance (which shields individuals from facing the full price of services), will also contribute to increases in health care spending.

Chart 1-7. Changes in spending per enrollee, Medicare and private health insurance

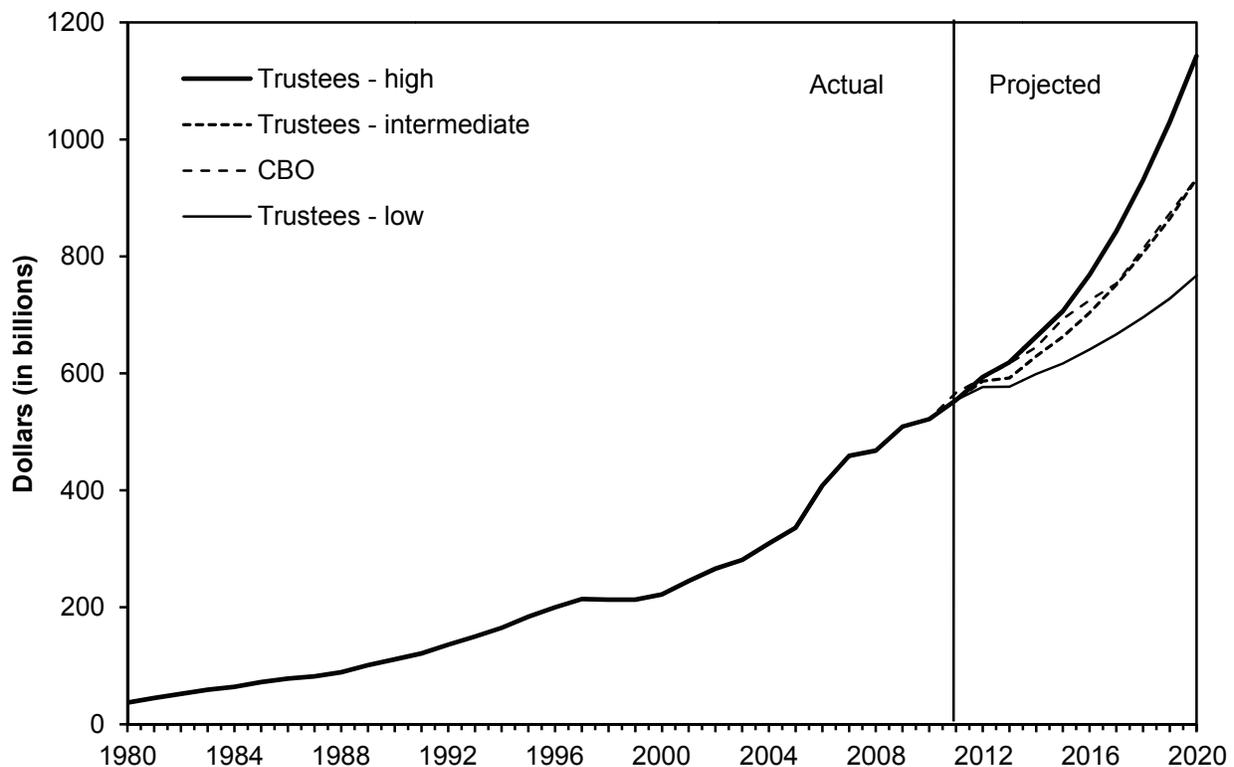


Note: PHI (private health insurance). For the most part, during this period, Medicare and PHI did not cover the same services. Medicare expenditures include both fee-for-service and private plans.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, 2012.

- Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar. However, this comparison is sensitive to the end points of the time one uses for calculating average growth rates. Also, private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population that tends to be more costly. In addition, the data do not allow analysis of the extent to which these spending trends were affected by changes in the generosity of covered benefits and, in turn, changes in enrollees' out-of-pocket spending.
- Differences appear to be more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services. Some analysts believe that, since the mid-1980s, Medicare has had greater success at containing cost growth than private payers by using its larger purchasing power. Others maintain that, since the 1970s, benefits offered by private insurers have expanded and cost-sharing requirements declined. These factors make the comparison problematic, as Medicare's benefits changed little over the same period.

Chart 1-8. Trustees and CBO project Medicare spending to grow at an annual average rate of around 6 percent over the next 10 years

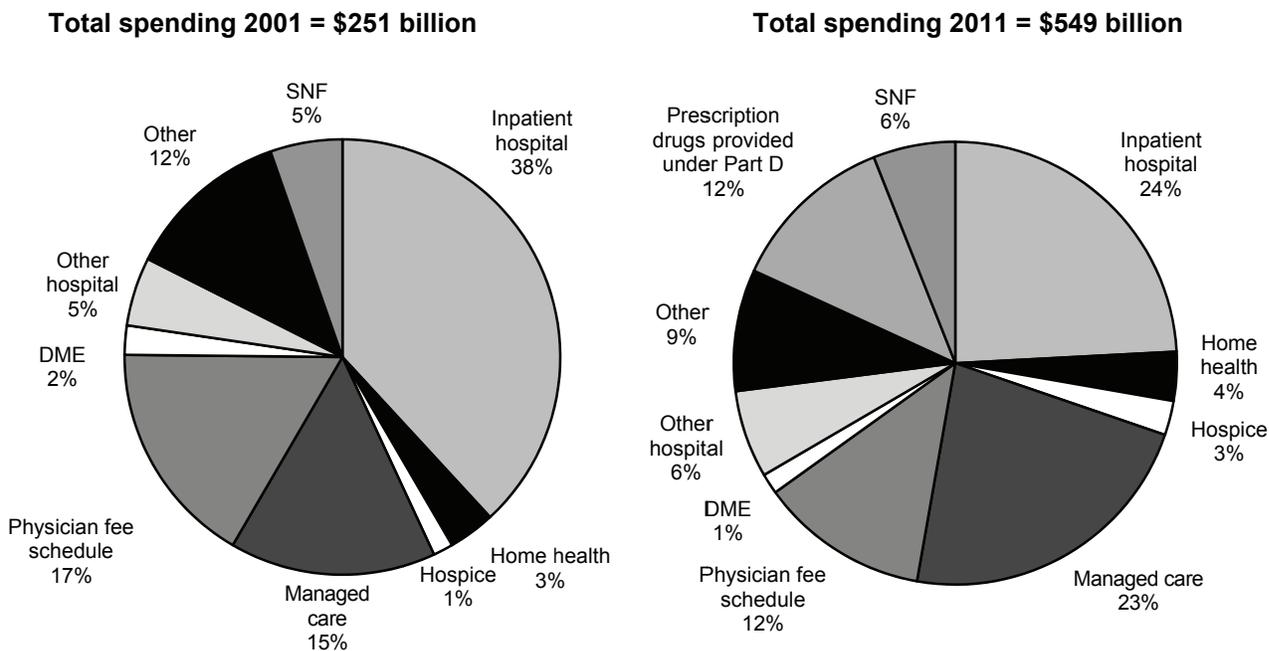


Note: CBO (Congressional Budget Office). All data are nominal, gross program outlays (mandatory plus administrative expenses) by calendar year.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds; CBO March 2012 baseline.

- Medicare spending has grown 14-fold over the past three decades, from \$37 billion in 1980 to \$522 billion in 2010 (see Chart 1-3; these data include benefit payments and administrative expenses).
- Medicare spending increased significantly after 2006 with the introduction of Part D, Medicare’s voluntary outpatient prescription drug benefit.
- CBO projects that mandatory spending for Medicare will grow at an average annual rate of 6.1 percent between 2011 and 2021. The Medicare trustees’ intermediate projections for 2011 to 2021 also assume 6.1 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect provider payment annual updates) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-9. Medicare spending is concentrated in certain services and has shifted over time

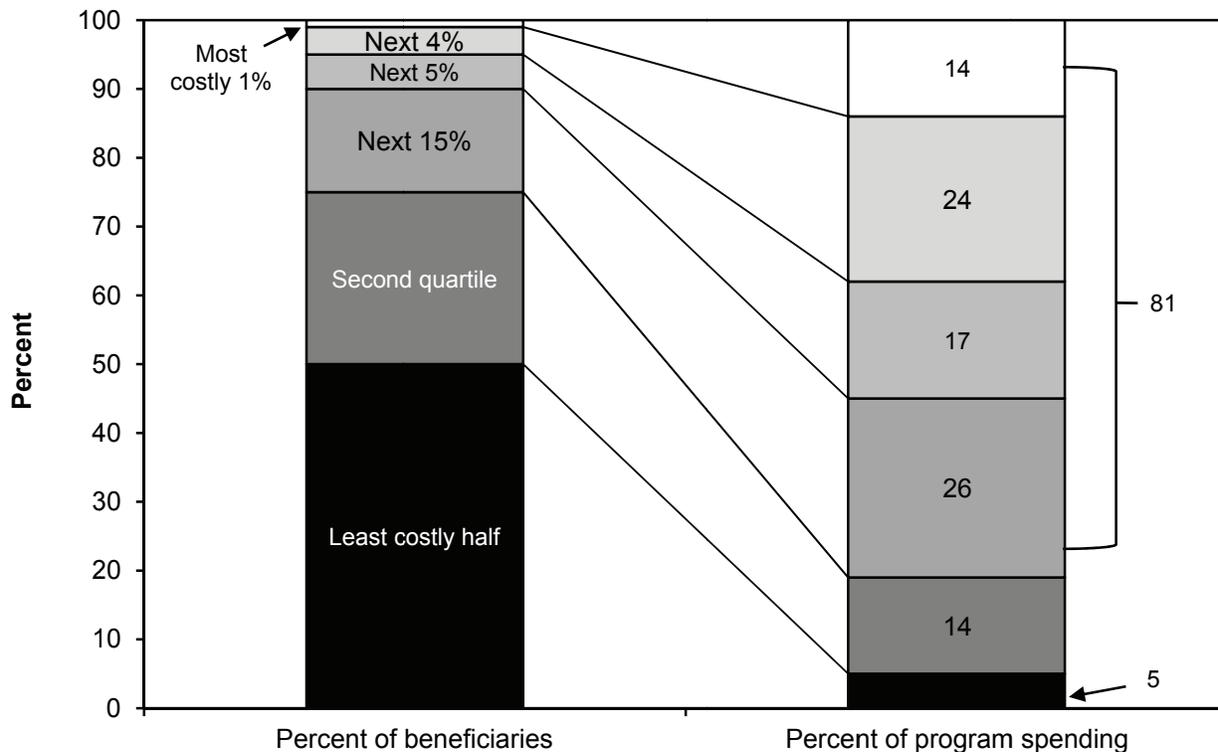


Note: SNF (skilled nursing facility), DME (durable medical equipment). Spending amounts are gross outlays, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or spending on their behalf) for cost-sharing requirements of Medicare-covered services. Values are reported on a fiscal year, incurred basis and do not include spending on program administration. "Other" includes carrier lab, other carrier, intermediary lab, and other intermediary. Totals may not sum to 100 percent due to rounding.

Source: 2012 President's Budget; CMS Office of the Actuary, 2012.

- The distribution of Medicare spending among services has changed substantially over time.
- In 2011, Medicare spent about \$549 billion for benefit expenses. Inpatient hospital services were the largest spending category (24 percent), followed by managed care (23 percent), services reimbursed under the physician fee schedule (12 percent), outpatient prescription drugs provided under Part D (12 percent), and other fee-for-service settings (9 percent).
- Although inpatient hospital services still made up the largest spending category, spending for those services was a smaller share of total Medicare spending in 2011 than it was in 2001, falling from 38 percent to 24 percent. Spending on beneficiaries enrolled in managed care plans has grown from 15 percent to 23 percent over the same period. Current Medicare managed care enrollment is higher than it was a decade ago.

Chart 1-10. FFS program spending is highly concentrated in a small group of beneficiaries, 2008



Note: FFS (fee-for-service). Excludes beneficiaries with any group health enrollment during the year.

Source: MedPAC analysis of 2008 Medicare Current Beneficiary Survey, Cost and Use files.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2008, the costliest 5 percent of beneficiaries accounted for 38 percent of annual Medicare FFS spending and the costliest quartile accounted for 81 percent. By contrast, the least costly half of beneficiaries accounted for only 5 percent of FFS spending.
- Costly beneficiaries tend to include those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2024 under actuaries' intermediate assumptions

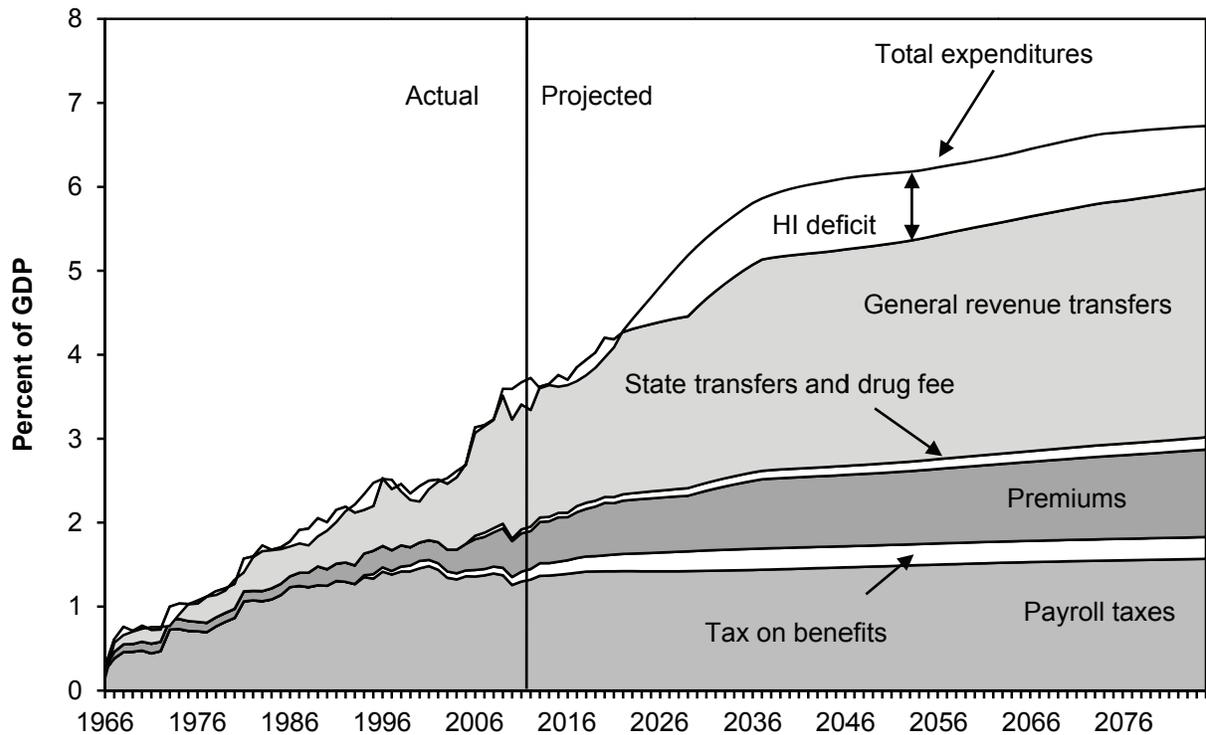
Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2017
Intermediate	2008	2024
Low	2008	Never*

Note: HI (Hospital Insurance). Income includes taxes (payroll and Social Security benefits taxes, railroad retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.
 * Under the low-cost assumption, trust fund assets would start to increase in 2014 and continue to increase throughout the projection period.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds; CMS Office of the Actuary.

- The Medicare program is financed through two trust funds: one for HI, which covers services provided by hospitals and other providers such as skilled nursing facilities, and one for Supplementary Medical Insurance (SMI) services, such as physician visits and Medicare's prescription drug benefit. Dedicated payroll taxes on current workers largely finance HI spending and are held in the HI trust fund. The HI trust fund can be exhausted if spending exceeds payroll tax revenues and fund reserves. General revenues finance roughly 75 percent of SMI services, and beneficiary premiums finance about 25 percent. (General revenues are federal tax dollars that are not dedicated to a particular use, but are made up of income and other taxes on individuals and corporations.)
- The SMI trust fund is financed with general revenues and beneficiary premiums. Some analysts believe that the levels of premiums and general revenues required to finance projected spending for SMI services would impose a significant burden on Medicare beneficiaries and on growth in the U.S. economy.
- HI's expenses exceeded its income in 2008. In 2012, Medicare trustees report that, under the intermediate assumptions, the HI trust fund will be exhausted in 2024. Under high-cost assumptions, the HI trust fund could be exhausted as early as 2017. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

Chart 1-12. Medicare faces serious challenges with long-term financing

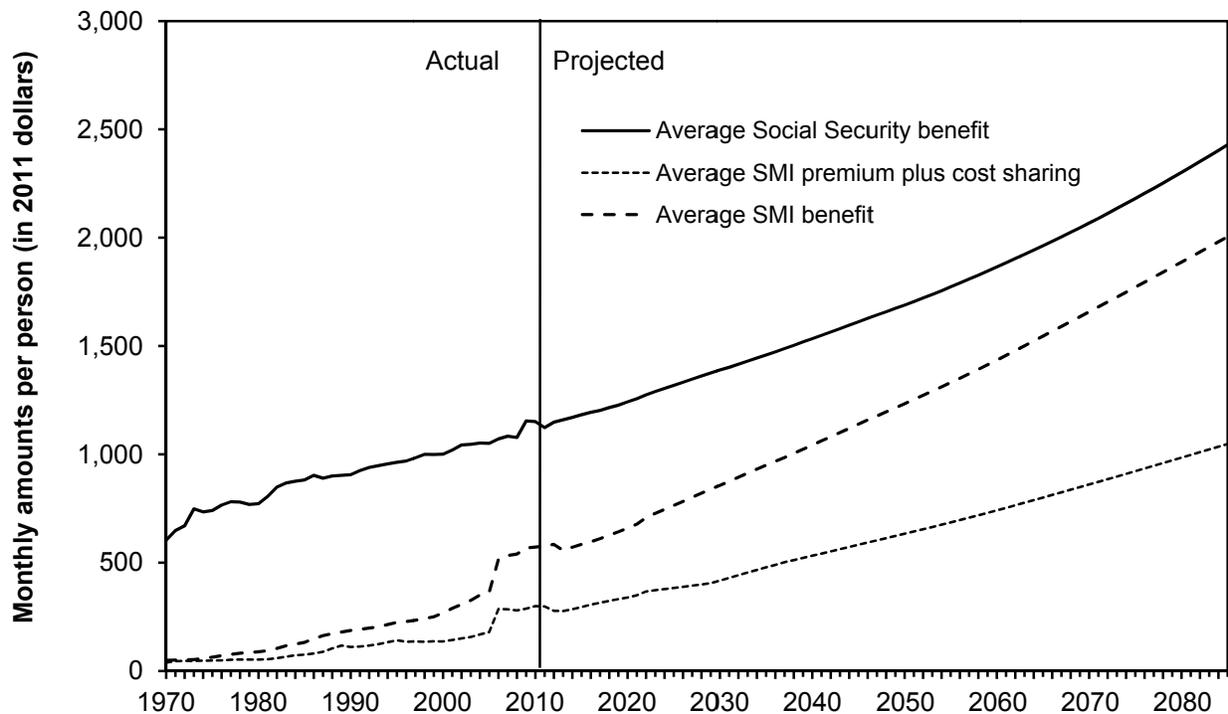


Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. The drug fee refers to the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the SMI trust fund.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Under an intermediate set of assumptions, trustees project that Medicare spending will grow rapidly, from about 3.6 percent of GDP today to 6.0 percent by 2040 and about 6.7 percent by 2080.

Chart 1-13. Average monthly SMI premiums and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs before 2006 is not included.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Between 1970 and 2010, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average SMI premiums plus cost sharing grew by an annual average of 5.2 percent, and the value of the total SMI benefit grew by an annual average of 6.3 percent.
- Growth over time in Medicare premiums and cost sharing will continue to outpace growth in Social Security income. Medicare trustees project that between 2010 and 2040 the average Social Security benefit will grow by 1 percent annually (after adjusting for inflation), compared with about 1.9 percent annual growth in average SMI premiums plus cost sharing.
- Most Medicare beneficiaries pay their Part B premium by having it withheld from their monthly Social Security benefits. The December 2012 cost-of-living adjustment for Social Security benefits is projected to be 1.8 percent under intermediate assumptions.

Chart 1-14. Medicare HI and SMI program payments and cost sharing per beneficiary in 2010

	Average program payment (in dollars)	Average cost-sharing amount (in dollars)
HI	\$4,954	\$437
SMI	4,811	1,242

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance). Average program payments and cost-sharing amounts are for fee-for-service Medicare only and do not include Part D. Medicare program payments represent unadjusted amounts paid for covered services incurred during a calendar year under Medicare fee-for-service only and exclude payments for managed care services. Program payments differ from benefit payments, which reflect estimates of interim and retroactive adjustments made to institutional providers, as well as payments for managed care.

Source: Medicare and Medicaid Statistical Supplement 2012, CMS Office of Information Services.

- In calendar year 2010, the Medicare program made \$4,954 in HI program payments and \$4,811 in SMI program payments on average per beneficiary.
- In the same year, beneficiaries owed an average of \$1,679 in Medicare cost sharing for HI and SMI.
- Most Medicare beneficiaries have supplemental coverage through former employers, medigap policies, Medicaid, or other sources that fill in much of Medicare's cost-sharing requirements.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/ReportsTrustFunds/>

- The National Health Expenditure Accounts developed by the Office of the Actuary at CMS provide information about spending for health care in the United States.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/>

- The Medicare & Medicaid Statistical Supplement developed by CMS provides statistical information about Medicare, Medicaid, and other CMS programs.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html?redirect=/MedicareMedicaidStatSupp/>

- CMS statistics listed in its Data Compendium provide information about Medicare beneficiaries, providers, utilization, and spending.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/index.html?redirect=/DataCompendium/>

- MedPAC's March 2012 Report to the Congress provides an overview of Medicare and U.S. health care spending in Chapter 1, Context for Medicare Payment Policy.

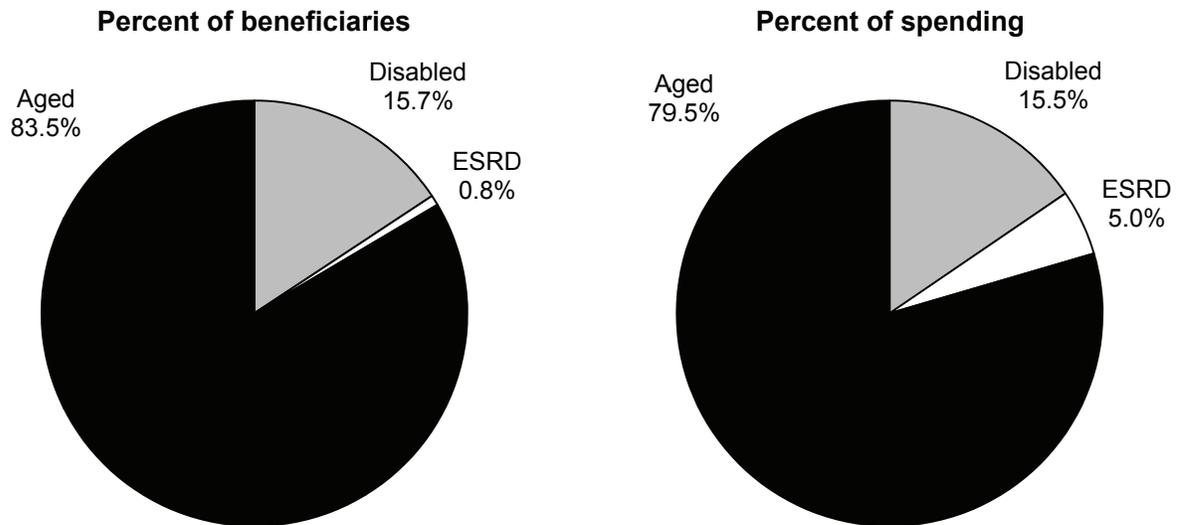
http://www.medpac.gov/chapters/Mar12_Ch01.pdf

SECTION

2

**Medicare beneficiary
demographics**

Chart 2-1. Aged beneficiaries account for the greatest share of the Medicare population and program spending, 2008

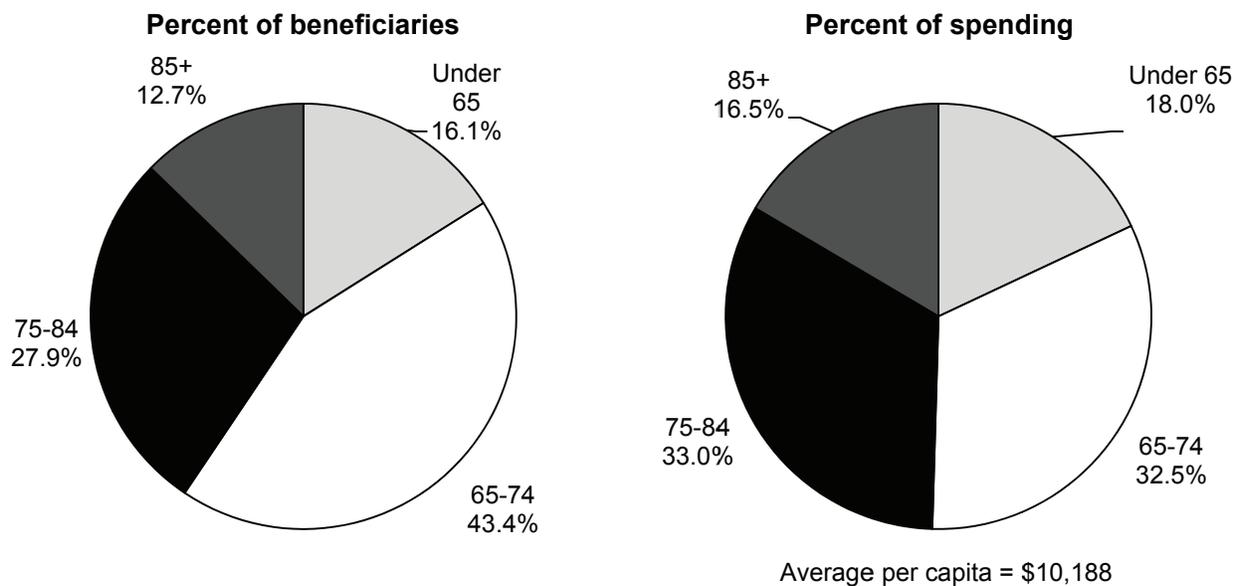


Note: ESRD (end-stage renal disease). The aged category refers to beneficiaries age 65 or older without ESRD. The disabled category refers to beneficiaries under age 65 without ESRD. The ESRD category refers to beneficiaries with ESRD. Results include fee-for-service, Medicare Advantage, community dwelling, and institutionalized beneficiaries. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- In 2008, aged beneficiaries 65 and older without ESRD composed 83.5 percent of the beneficiary population and accounted for 79.5 percent of Medicare spending. Beneficiaries under 65 with disability and beneficiaries with ESRD accounted for the remaining population and spending.
- In 2008, average Medicare spending per beneficiary was \$10,188.
- A disproportionate share of Medicare expenditures is devoted to Medicare beneficiaries with ESRD. On average, these beneficiaries incur spending that is more than six times greater than aged beneficiaries 65 years or older (without ESRD) and beneficiaries under age 65 with (non-ESRD) disability. In 2008, \$65,256 was spent per ESRD beneficiary versus \$9,676 per aged beneficiary 65 years or older (without ESRD), and \$10,010 per beneficiary under age 65 enrolled due to disability.

Chart 2-2. Medicare enrollment and spending by age group, 2008

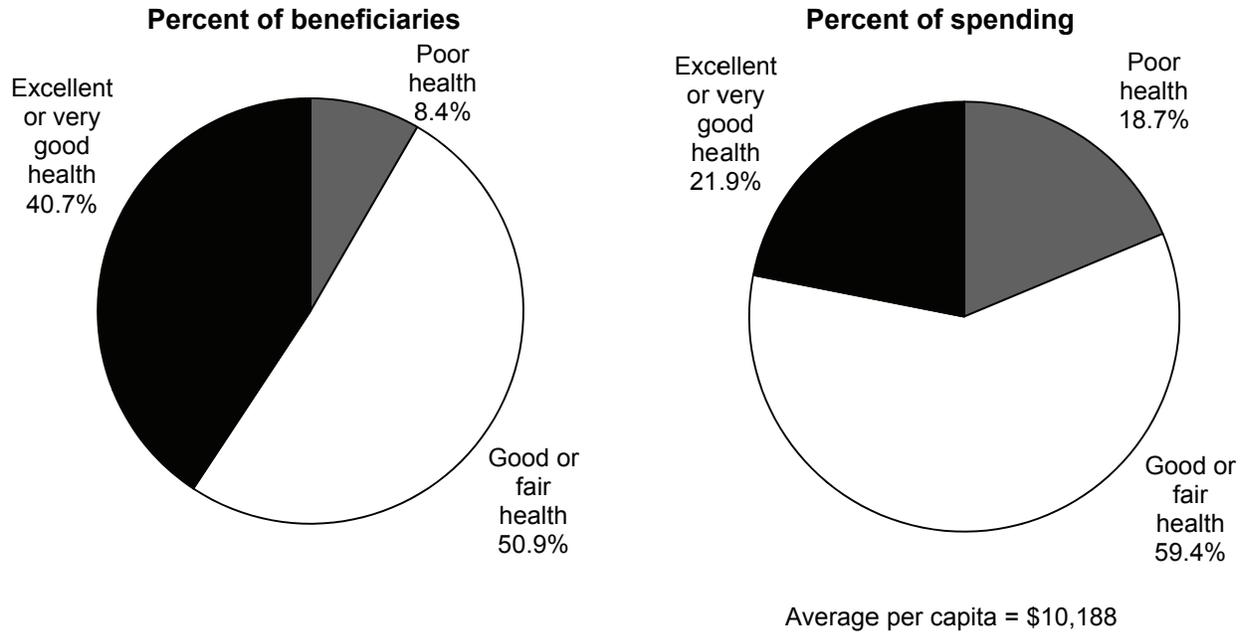


Note: Results include fee-for-service, Medicare Advantage, community dwelling, and institutionalized beneficiaries. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- For the aged population (65 or older), per capita expenditures increase with age. In 2008, per capita expenditures were \$7,626 for beneficiaries aged 65 to 74, \$12,077 for those 75 to 84, and \$13,219 for those 85 or older.
- In 2008, per capita expenditures for Medicare beneficiaries under age 65 enrolled due to end-stage renal disease or disability were \$11,426.

Chart 2-3. Beneficiaries who report being in poor health account for a disproportionate share of Medicare spending, 2008

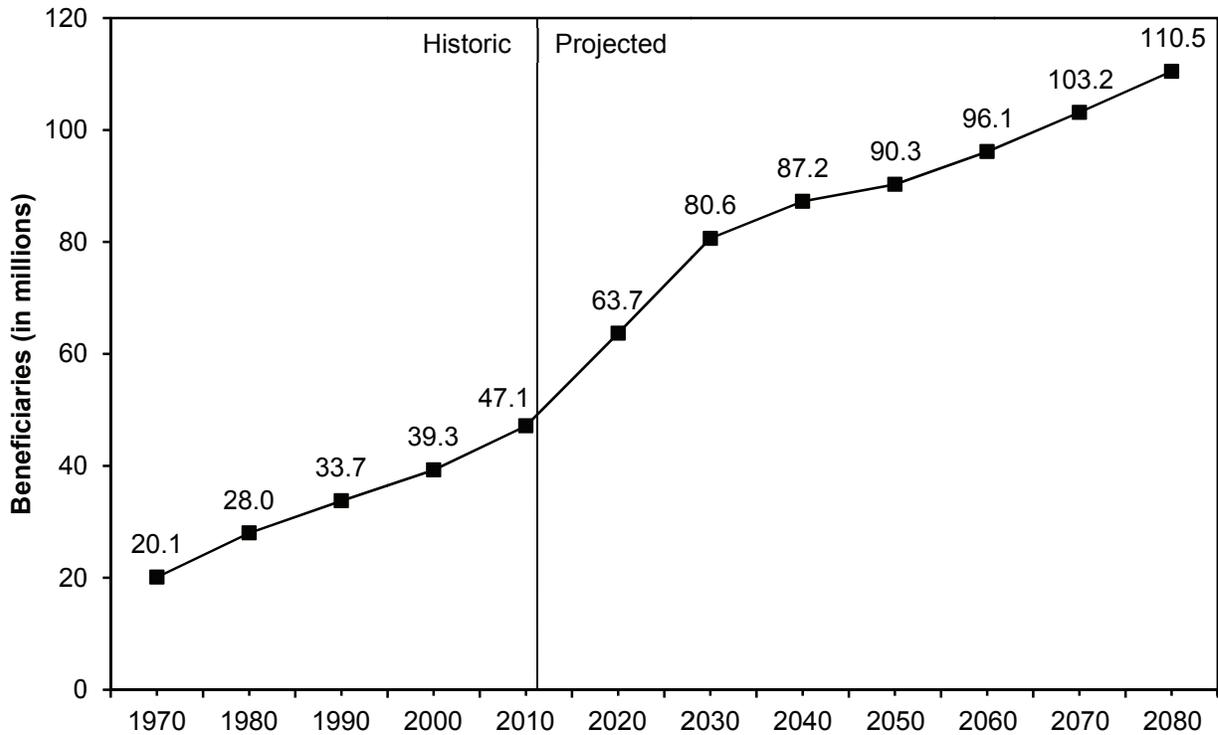


Note: Results include fee-for-service, Medicare Advantage, community dwelling, and institutionalized beneficiaries. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- In 2008, most beneficiaries reported fair to excellent health. Fewer than 10 percent reported poor health.
- Medicare spending is strongly associated with self-reported health status. In 2008, per capita expenditures were \$5,437 for those who reported excellent or very good health, \$11,795 for those who reported good or fair health, and \$22,612 for those who reported poor health.

Chart 2-4. Enrollment in the Medicare program is projected to grow rapidly in the next 20 years



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

Source: CMS Office of the Actuary, 2012.

- The total number of people enrolled in the Medicare program will increase from 47 million in 2010 to 81 million in 2030.
- The rate of increase in Medicare enrollment will accelerate until 2030 as more members of the baby-boom generation become eligible, at which point it will increase more slowly after the entire baby-boom generation has become eligible.

Chart 2-5. Characteristics of the Medicare population, 2008

Characteristic	Percent of the Medicare population	Characteristic	Percent of the Medicare population
Total (46,048,125)	100%	Living arrangement	
Sex		Institution	5%
Male	45	Alone	29
Female	55	Spouse	49
		Other	18
Race/ethnicity		Education	
White, non-Hispanic	78	No high school diploma	25
African American, non-Hispanic	9	High school diploma only	31
Hispanic	8	Some college or more	44
Other	5	Income status	
Age		Below poverty	17
<65	16	100–125% of poverty	9
65–74	43	125–200% of poverty	19
75–84	28	200–400% of poverty	31
85+	13	Over 400% of poverty	24
Health status		Supplemental insurance status	
Excellent or very good	41	Medicare only	9
Good or fair	51	Managed care	23
Poor	8	Employer	33
Residence		Medigap	16
Urban	76	Medigap/employer	4
Rural	24	Medicaid	14
		Other	1

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2008, poverty was defined as income of \$10,326 for people living alone and as \$13,030 for married couples. Totals may not sum to 100 percent due to rounding. Some beneficiaries may have more than one type of supplemental insurance.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- Close to one-quarter of beneficiaries live in rural areas.
- Twenty-nine percent of the Medicare population lives alone.
- One-quarter of beneficiaries have no high school diploma.
- Most Medicare beneficiaries have some source of supplemental insurance.

Web links. Medicare beneficiary demographics

- CMS Data Compendium contains historic, current, and projected data on Medicare enrollment.

<http://www.cms.gov/DataCompendium/>

- The CMS website provides information on Medicare enrollment by state.

<http://www.cms.gov/MedicareEnRpts>

- The CMS website provides information about the Medicare Current Beneficiary Survey, a resource on the demographic characteristics of Medicare beneficiaries.

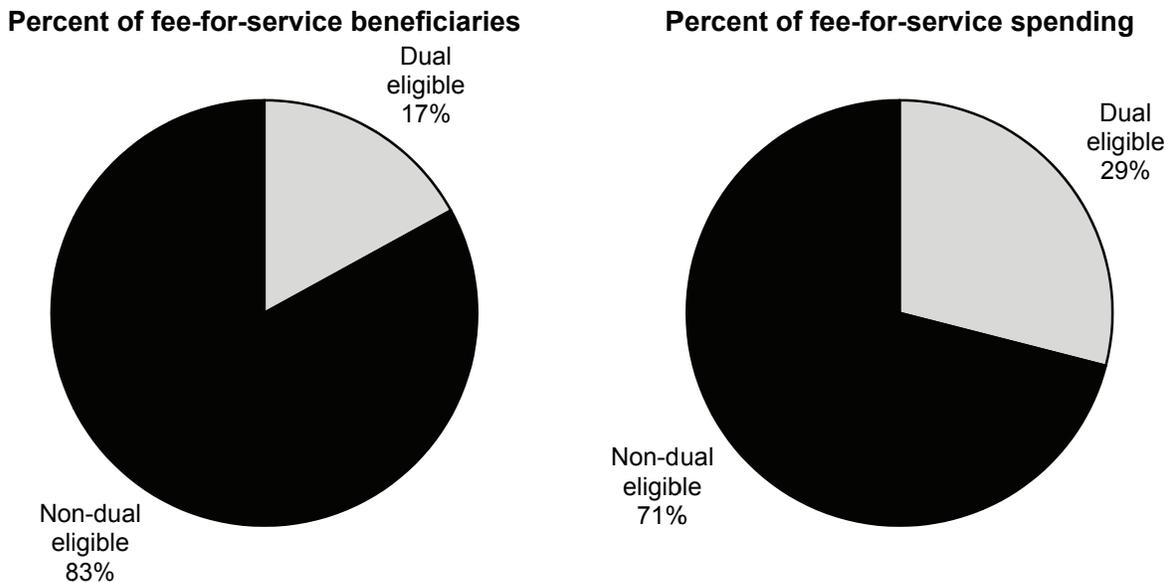
<http://www.cms.gov/mcbs>

SECTION

3

**Dual-eligible
beneficiaries**

Chart 3-1. Dual-eligible beneficiaries account for a disproportionate share of Medicare spending, 2008

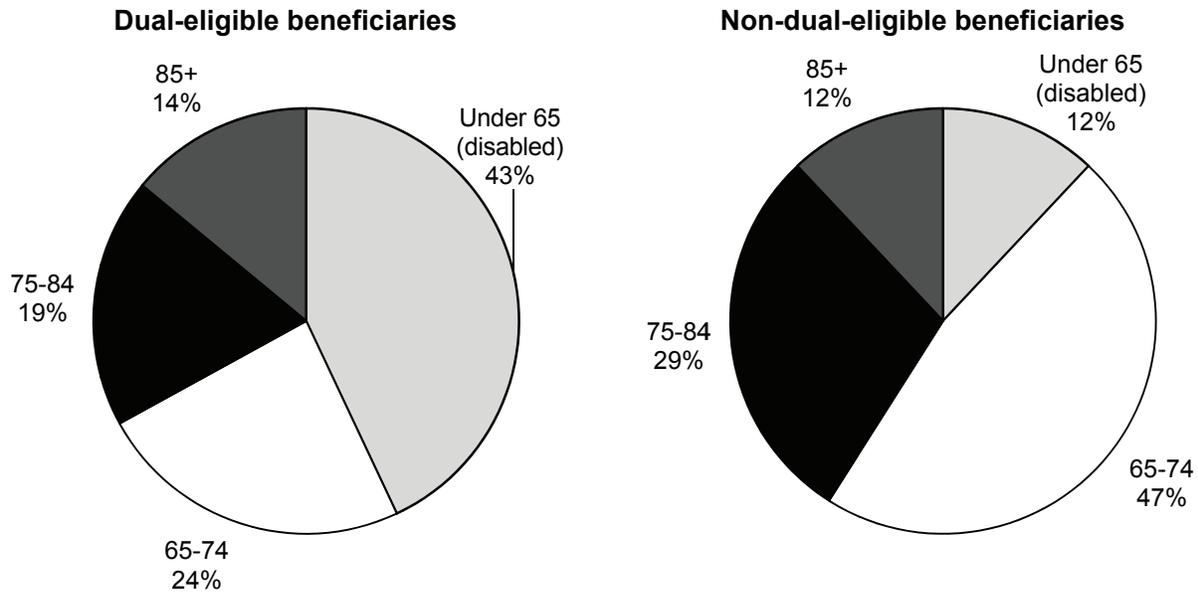


Note: Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for supplemental insurance. Spending data reflect 2008 Medicare Current Beneficiary Survey Cost and Use file from CMS.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- Dual-eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help low-income persons obtain needed health care.
- Dual-eligible beneficiaries account for a disproportionate share of Medicare expenditures: As 17 percent of the Medicare fee-for-service population, they represent 29 percent of aggregate Medicare fee-for-service spending.
- On average, dual-eligible beneficiaries incur twice as much annual fee-for-service Medicare spending as non-dual-eligible beneficiaries: \$16,395 is spent per dual-eligible beneficiary, and \$8,161 is spent per non-dual-eligible beneficiary.
- In 2008, average total spending—which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers—for dual-eligible beneficiaries was about \$29,600 per beneficiary, twice the amount for other Medicare beneficiaries.

Chart 3-2. Dual-eligible beneficiaries are more likely than non-dual eligibles to be disabled, 2008

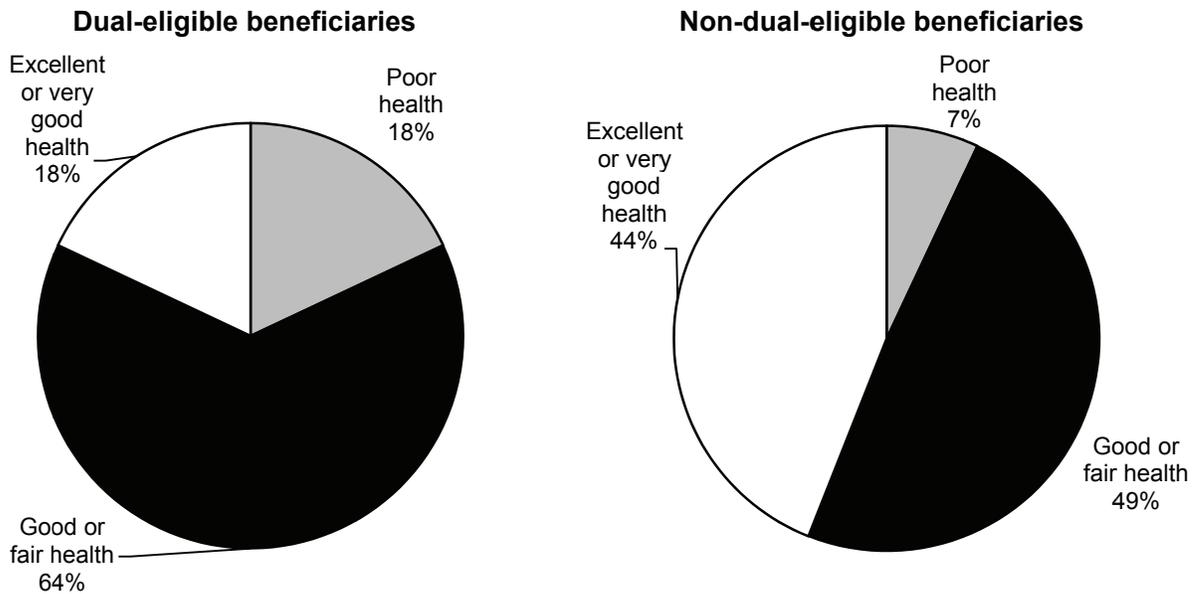


Note: Beneficiaries who are under age 65 qualify for Medicare because they are disabled. Once disabled beneficiaries reach age 65, they are counted as aged. Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for supplemental insurance.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to be under age 65 and disabled. Forty-three percent of dual-eligible beneficiaries are under age 65 and disabled, compared with 12 percent of the non-dual-eligible population.

Chart 3-3. Dual-eligible beneficiaries are more likely than non-dual eligibles to report poorer health status, 2008



Note: Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for supplemental insurance.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to report poorer health status. Most report good or fair status, but 18 percent of the dual-eligible population reports being in poor health (compared with 7 percent of the non-dual-eligible population).
- Dual-eligible beneficiaries are more likely to have cognitive impairment and mental disorders. They also have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer’s disease than do non-dual-eligible beneficiaries.

Chart 3-4. Demographic differences between dual-eligible beneficiaries and non-dual eligibles, 2008

Characteristic	Percent of dual-eligible beneficiaries	Percent of non-dual-eligible beneficiaries
Sex		
Male	39%	46%
Female	61	54
Race/ethnicity		
White, non-Hispanic	57	81
African American, non-Hispanic	20	8
Hispanic	13	7
Other	10	4
Limitations in ADLs		
No ADLs	45	71
1–2 ADLs	23	20
3–6 ADLs	32	9
Residence		
Urban	69	77
Rural	31	22
Living arrangement		
Institution	20	2
Alone	29	28
Spouse	16	54
Children, nonrelatives, others	34	15
Education		
No high school diploma	50	20
High school diploma only	25	31
Some college or more	22	48
Income status		
Below poverty	58	10
100–125% of poverty	20	7
125–200% of poverty	16	19
200–400% of poverty	5	35
Over 400% of poverty	1	27
Supplemental insurance status		
Medicare or Medicare/Medicaid only	90	11
Medicare managed care	3	26
Employer	2	39
Medigap	1	19
Medigap/employer	0	5
Other*	3	1

Note: ADL (activity of daily living). Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for other supplemental insurance. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2008, poverty was defined as income of \$10,326 for people living alone and \$13,030 for married couples. Totals may not sum to 100 percent due to rounding and exclusion of an “other” category. *Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- Dual-eligible beneficiaries qualify for Medicaid due to low incomes: Fifty-eight percent live below the poverty level, and 94 percent live below 200 percent of poverty. Compared with non-dual-eligible beneficiaries, dual-eligible beneficiaries are more likely to be female; to be African American or Hispanic; to lack a high school diploma; to have greater limitations in activities of daily living; to reside in a rural area; and to live in an institution. They are less likely to have sources of supplemental coverage other than Medicaid.

Chart 3-5. Differences in spending and service use rate between dual-eligible beneficiaries and non-dual eligibles, 2008

Service	Dual-eligible beneficiaries	Non-dual-eligible beneficiaries
Average Medicare payment for all beneficiaries		
Total Medicare payments	\$16,699	\$9,140
Inpatient hospital	4,971	2,869
Physician ^a	2,873	2,339
Outpatient hospital	1,833	927
Home health	641	406
Skilled nursing facility ^b	1,120	424
Hospice	509	175
Prescribed medication ^c	4,424	995
Percent of beneficiaries using service		
Percent using any type of service	95.9%	87.1%
Inpatient hospital	25.8	17.5
Physician ^a	91.1	83.6
Outpatient hospital	74.1	60.4
Home health	10.9	8.1
Skilled nursing facility ^b	8.6	3.7
Hospice	4.1	1.6
Prescribed medication ^c	73.8	41.2

Note: Not restricted to beneficiaries in fee-for-service. Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for supplemental insurance. Spending totals derived from the Medicare Current Beneficiary Survey (MCBS) do not necessarily match official estimates from CMS, Office of the Actuary. Total payments may not equal the sum of line items as some minor items have been omitted. Spending data reflect 2008 Medicare Current Beneficiary Survey Cost and Use file from CMS.

^a Includes a variety of medical services, equipment, and supplies.

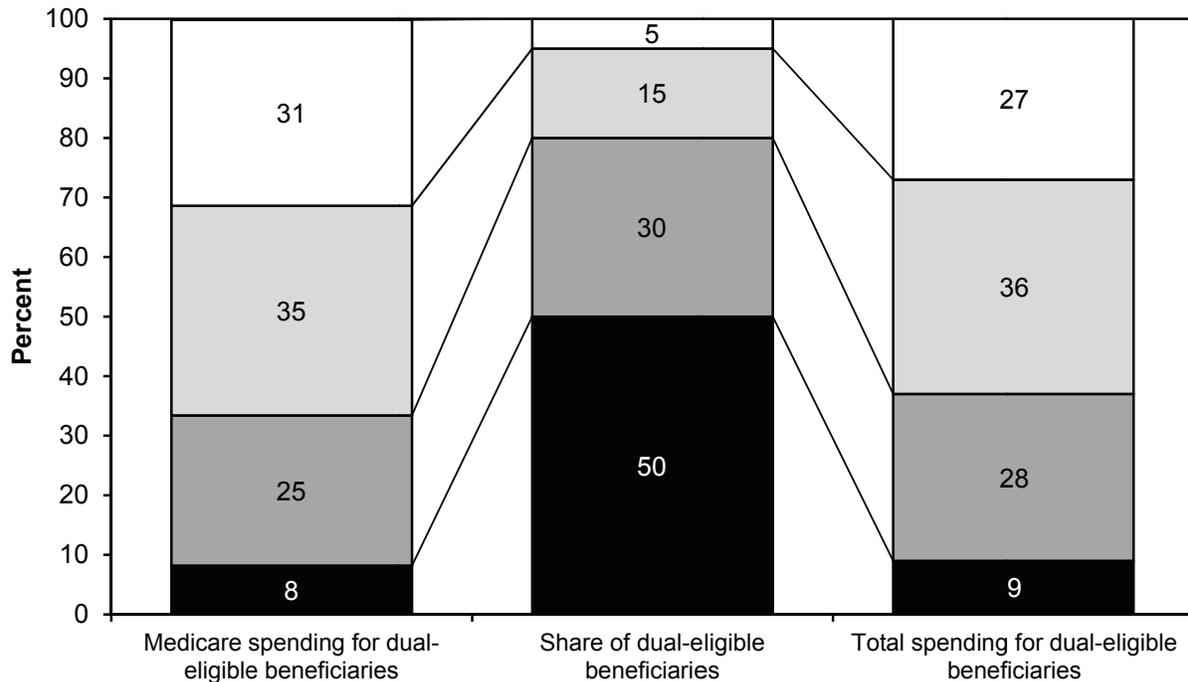
^b Individual short-term facility (usually skilled nursing facility) stays for the Medicare Current Beneficiary Survey population.

^c CMS changed the methodology for collecting prescription drug data in the MCBS in 2007. Before 2007, all prescription drug data were based on information collected in the survey; however, starting in 2007, CMS began collecting prescription drug data for the MCBS from Medicare Advantage—Prescription Drug plans and prescription drug plans.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use file, 2008.

- Average per capita Medicare spending for dual-eligible beneficiaries is more than 1.8 times that for non-dual-eligible beneficiaries—\$16,699 compared with \$9,140.
- For each type of service, average Medicare per capita spending is higher for dual-eligible beneficiaries than for non-dual-eligible beneficiaries.
- Higher average per capita spending for dual-eligible beneficiaries is a function of a higher service use rate than their non-dual-eligible counterparts.
- Dual-eligible beneficiaries are more likely to use each type of Medicare-covered service than non-dual-eligible beneficiaries.

Chart 3-6. Both Medicare and total spending are concentrated among dual-eligible beneficiaries, 2008



Note: Total spending includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending. Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for supplemental insurance. Totals may not sum to 100 percent due to rounding. Spending data reflect 2008 Medicare Current Beneficiary Survey Cost and Use file from CMS.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost and Use files, 2008.

- Annual Medicare spending is concentrated among a small number of dual-eligible beneficiaries. The costliest 20 percent of dual eligibles account for 66 percent of Medicare spending and 63 percent of total spending on dual-eligible beneficiaries. In contrast, the least costly 50 percent of dual-eligible beneficiaries account for only 8 percent of Medicare spending and 9 percent of total spending on dual-eligible beneficiaries.
- On average, total spending for dual-eligible beneficiaries is twice that for non-dual-eligible beneficiaries—\$29,600 compared with \$14,700.

Web links. Dual-eligible beneficiaries

- Chapter 3 of the MedPAC June 2012 Report to the Congress provides information on dual-eligible beneficiaries.

http://www.medpac.gov/chapters/Jun12_Ch03.pdf

- Chapter 5 of the MedPAC June 2011 Report to the Congress provides information on dual-eligible beneficiaries.

http://www.medpac.gov/chapters/Jun11_Ch05.pdf

- Chapter 5 of the MedPAC June 2010 Report to the Congress provides further information on dual-eligible beneficiaries.

http://www.medpac.gov/chapters/Jun10_Ch05.pdf

- The Kaiser Family Foundation provides information on dual-eligible beneficiaries.

<http://www.kff.org/medicare/resources-dual-eligibles.cfm>

- Further information on dual eligibles is available from the CMS Medicare–Medicaid Coordination Office.

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>

SECTION

4

**Quality of care in the
Medicare program**

Chart 4-1. In-hospital and 30-day post-discharge mortality rates improved from 2007 to 2010

Condition or procedure	Risk-adjusted rate per 100 eligible discharges, 2007	Risk-adjusted rate per 100 eligible discharges, 2010	Directional change in rate, 2007–2010
In-hospital mortality			
Acute myocardial infarction	9.31	7.33	Better
Congestive heart failure	4.41	3.54	Better
Stroke	11.72	10.00	Better
Hip fracture	3.23	3.09	No difference
Pneumonia	4.73	3.73	Better
30-day post-discharge mortality			
Acute myocardial infarction	13.29	11.38	Better
Congestive heart failure	10.98	9.56	Better
Stroke	24.90	23.10	Better
Hip fracture	8.59	8.24	No difference
Pneumonia	10.65	9.10	Better

Note: Rates are calculated based on the discharges eligible to be counted in each measure. Rates do not include deaths in non-inpatient prospective payment system hospitals or Medicare Advantage plans. “Better” indicates that the risk-adjusted rate decreased by a statistically significant amount from 2006 to 2009 using a $p \leq 0.01$ criterion. “No difference” indicates that the change in the rate was not statistically significant from 2006 to 2009 using a $p \leq 0.01$ criterion.

Source: MedPAC analysis of CMS Medicare Provider Analysis and Review data using Agency for Healthcare Research and Quality Inpatient Quality Indicators Version 4.1b (with modifications for 30-day mortality rate calculations).

- Our most recent analysis of several inpatient quality indicators shows generally positive trends. We analyzed five of the Inpatient Quality Indicators developed by the Agency for Healthcare Research and Quality (AHRQ) to measure in-hospital and 30-day post-discharge mortality rates. Trends in risk-adjusted in-hospital mortality rates are used to assess changes in the quality of care provided to Medicare beneficiaries during inpatient stays for certain medical conditions. Thirty-day post-discharge mortality rates reflect the quality of care transitions and post-hospital care for beneficiaries in the critical period during and shortly after discharge from an inpatient stay.
- In-hospital and 30-day post-discharge mortality rates declined by a statistically significant amount for four of the five conditions monitored. From 2007 to 2010, both types of mortality rates declined by a statistically significant amount for acute myocardial infarction, congestive heart failure, stroke, and pneumonia as measured by the AHRQ methods. The in-hospital and 30-day mortality rate for patients admitted with hip fracture also declined, but not by a statistically significant amount.

Chart 4-2. Hospital inpatient patient safety indicators improved or were stable from 2007 to 2010

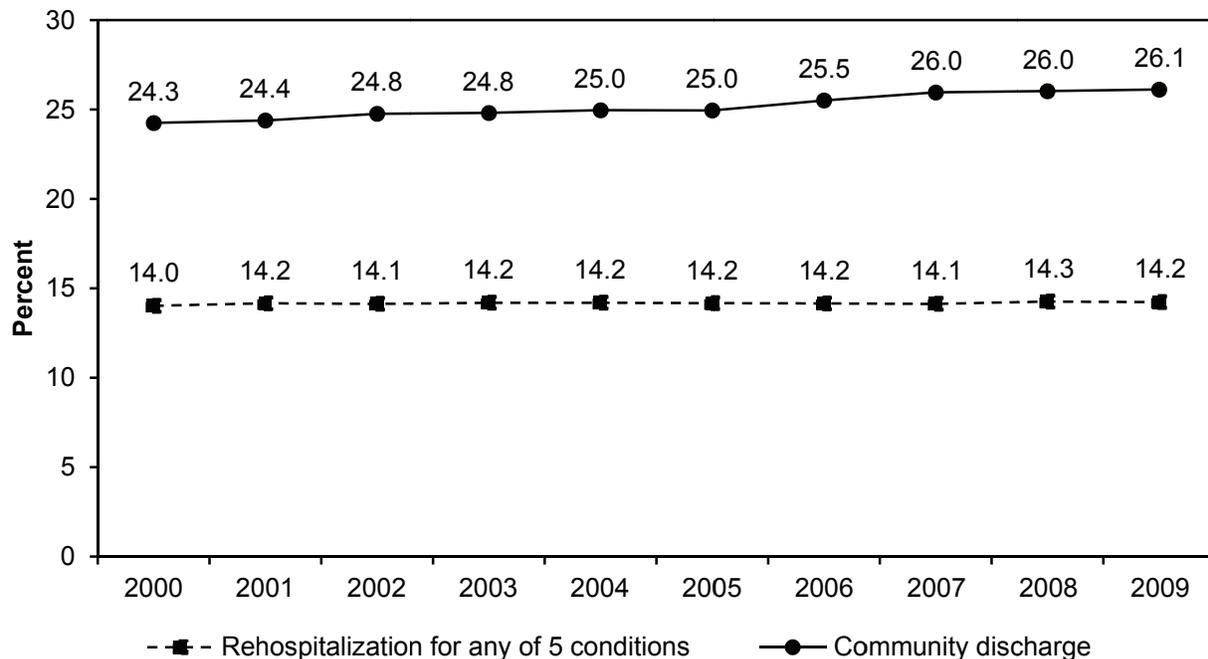
Patient safety indicator	Risk-adjusted rate per 100 eligible discharges, 2007	Risk-adjusted rate per 100 eligible discharges, 2010	Directional change in rate, 2007–2010
Death among surgical inpatients with treatable serious complications	10.16	11.45	Worse
Iatrogenic pneumothorax	0.07	0.02	Better
Postoperative respiratory failure	1.75	0.88	Better
Postoperative PE or DVT	1.01	0.41	Better
Postoperative wound dehiscence	0.27	0.22	Better
Accidental puncture or laceration	0.28	0.14	Better

Note: PE (pulmonary embolism), DVT (deep vein thrombosis). “Better” indicates that the risk-adjusted rate decreased by a statistically significant amount from 2007 to 2010 using a $p \leq 0.01$ criterion.

Source: MedPAC analysis of CMS Medicare Provider Analysis and Review data using Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators Version 4.1b.

- We also analyzed six of the AHRQ Patient Safety Indicators (PSIs), which measure the frequency of potentially preventable adverse events that can occur during an inpatient stay, such as the development of postoperative pulmonary embolism or deep vein thrombosis (development of a blood clot that can suddenly obstruct an artery or vein) or a patient’s death from treatable surgical complications. The rates are calculated using software from AHRQ and Medicare inpatient hospital discharge data.
- Rates improved from 2007 to 2010 for five of the six PSIs we analyzed, including iatrogenic pneumothorax (introduction of air into the pleural cavity during a medical procedure, which often causes the lung to collapse), postoperative respiratory failure, postoperative pulmonary embolism or deep-vein thrombosis, postoperative wound dehiscence (parting of the sutures of a surgical wound), and accidental puncture or laceration. The PSI that did not improve from 2007 to 2010 was the rate of deaths among surgical inpatients with treatable serious complications.
- Caution should be used in interpreting all the reported PSI rates. The PSIs measure rates of very rare events, and—even across all inpatient prospective payment system (IPPS) hospitals—it is difficult to detect statistically significant changes in these indicators. The reliability of some of the PSI rates can also be affected by variations in providers’ coding practices. Nonetheless, we monitored sector-level trends in selected PSIs as indicators, though not definitive evidence, of increases and decreases in rates of harm to patients resulting from their medical care that can be avoided if providers adhere to known clinical safety practices.

Chart 4-3. Risk-adjusted SNF quality measures show mixed results since 2000



Note: SNF (skilled nursing facility). Increases in rates of discharge to the community indicate improved quality. The five conditions include congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance. Increases in rehospitalization for the five conditions indicate worsening quality. Rates are calculated for all facilities with 25 or more stays.

Source: Rates calculated by MedPAC based on a risk adjustment model developed by the Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center.

- The Commission’s quality measures for skilled nursing facility care continue to show mixed results. Since 2000, risk-adjusted rates of community discharge showed slight improvement, while the rates of rehospitalization of patients with any of five potentially avoidable conditions exhibited almost no change. Both measures showed almost no change between 2008 and 2009.
- The 2009 risk-adjusted rate at which Medicare-covered SNF patients were rehospitalized for potentially avoidable conditions was 14.2 percent, almost the same as in 2000. The 2009 risk-adjusted rate of community discharge was 26 percent, up less than 2 percentage points from 2000.
- Across facilities, the risk-adjusted measures varied considerably (not shown). For example, facilities with the highest rates of rehospitalization of Medicare patients with any of five potentially avoidable conditions (the top 10th percentile) were more than double those of facilities with the lowest rates (the lowest 10th percentile).

Chart 4-4. Home health quality measures show limited change in 2011

Functional measures	2004	2005	2006	2007	2008	2009	2010	2011
Improvements in:								
Transferring	50%	51%	52%	53%	53%	54%	54%	53%
Bathing	59	61	62	63	64	64	65	64
Walking	N/A	55						
Medication management	N/A	46						
Pain management	N/A	66						

Note: N/A (not applicable). The measures for walking, medication management, and pain management changed in 2011, and therefore the 2011 results shown are not comparable to data from prior years.

Source: MedPAC analysis of OASIS, home health standard analytic file, and CMS Home Health Compare data.

- Medicare publishes risk-adjusted home health quality measures that track changes in the functional abilities for patients who receive home health care. These measures are reported for all home health episodes that do not terminate with a hospitalization.
- Since 2004, the rates of functional improvement have generally held steady or slightly improved each year. For example, the rate of patients demonstrating an improvement in their ability to bathe has increased from 59 percent to 64 percent.
- Avoiding hospitalization is an important outcome for many home health patients, and the Commission has developed a measure that tracks the rate of hospitalizations during the episode and up to 30 days after discharge from home health. The most recent data available for this measure are for 2007–2009. Under this measure, the risk-adjusted rate of hospitalization declined slightly from 27 percent in 2007 to 25 percent in 2009 (not shown on chart).

Chart 4-5. Dialysis quality of care: Some measures show progress, others need improvement

Outcome measure	2003	2007	2009	2010
Percent of in-center hemodialysis patients:				
Receiving adequate dialysis	94%	94%	95%	95%
Anemia measures				
Mean hemoglobin 10–12 g/dL	48	49	62	68
Mean hemoglobin \geq 13 g/dL*	15	14	7	5
Mean hemoglobin < 10 g/dL*	6	6	6	7
Dialyzed with an AV fistula	33	47	53	56
Percent of peritoneal dialysis patients:				
Receiving adequate dialysis	N/A	89	89	89
Anemia measures				
Mean hemoglobin 10–12 g/dL	45	48	57	58
Mean hemoglobin \geq 13 g/dL*	21	18	12	11
Mean hemoglobin < 10 g/dL*	7	7	10	11
Percent of prevalent dialysis patients wait-listed for a kidney				
	15	17	17	N/A
Renal transplant rate per 100 dialysis patient years				
	4.8	4.4	4.1	N/A
Annual mortality rate per 100 patient years*				
	21.4	19.2	18.0	N/A
Total admissions per patient year*				
	2.0	1.9	1.8	N/A
Hospital days per patient year				
	13.7	12.9	11.9	N/A

Note: g/dL (grams per deciliter of blood), AV (arteriovenous), N/A (not available). Data on dialysis adequacy, use of fistulas, and anemia management represent percent of patients meeting CMS's clinical performance measures. United States Renal Data System adjusts data by age, gender, race, and primary diagnosis of end-stage renal disease.
*Lower values suggest higher quality.

Source: Compiled by MedPAC from the Elab Project Report, Fistula First, and the United States Renal Data System.

- The quality of dialysis care has improved for some measures. All hemodialysis patients require vascular access—the site on the patient's body where blood is removed and returned during dialysis. Between 2003 and 2010, use of arteriovenous fistulas, considered the best type of vascular access, increased from 33 percent to 56 percent of hemodialysis patients. Between 2003 and 2010, overall adjusted mortality rates decreased, but remained high among dialysis patients.
- The quality of dialysis care has remained steady for some measures. Between 2003 and 2010, the proportion of hemodialysis patients receiving adequate dialysis remained high. Overall rates of hospitalization remained steady at about two admissions per dialysis patient per year.
- Other measures suggest that improvements in dialysis quality are still needed. We looked at access to kidney transplantation because it is widely believed that it is the best treatment option for individuals with end-stage renal disease. The proportion of dialysis patients accepted on the kidney transplant waiting list remains low. The falloff in the rate of kidney transplantation is partly due to a decrease in live organ donations during this period.

Chart 4-6. Medicare Advantage quality measures show improvement between 2010 and 2011

Measures	HMO averages		Local PPO averages	
	2010	2011	2010	2011
HEDIS[®] administrative measures				
Breast cancer screening	69.1	68.5	66.1 ^b	66.1 ^b
Glaucoma testing	62.1	63.8	64.2	65.5
Monitoring of patients taking long-term medications	89.1	90.2 ^a	89.7	90.7 ^a
At least one primary care doctor visit in the last year	93.7	94.0	95.6 ^b	95.6 ^b
Osteoporosis management	20.7	20.7	18.1 ^b	18.7
Rheumatoid arthritis management	72.3	72.8	76.9 ^b	78.3 ^b
HEDIS[®] hybrid measures				
Colorectal cancer screening ^c	54.7	57.6 ^a	a	41.3 ^c
Cholesterol screening for patients with heart disease	88.4	88.5	a	87.1 ^b
Controlling blood pressure	59.7	61.9 ^a	a	55.8 ^b
Cholesterol screening for patients with diabetes	87.3	87.9	a	86.3 ^b
Eye exam to check for damage from diabetes	63.5	64.6	a	62.7
Kidney function testing for members with diabetes	88.5	89.2 ^a	a	87.3 ^b
Diabetics with cholesterol is under control	49.9	52.2 ^a	a	45.9 ^b
Diabetics not controlling blood sugar (lower rate better)	28.1	25.9	a	34.3 ^b
Measures from HOS^d				
Monitoring physical activity	46.9	47.9 ^a	48.1 ^b	47.6
Improving bladder control	35.4	36.0	37.9 ^b	36.6
Reducing the risk of falling	58.2	60.5 ^a	54.4 ^b	55.1 ^b
Other measures based on HOS				
Improving or maintaining physical health	66.6	66.4	67.3	66.1
Improving or maintaining mental health	76.9	77.5	77.7	78.5 ^b
Measures from CAHPS[®]				
Annual flu vaccine	64.3	67.9 ^a	65.3	68.6 ^a
Pneumonia vaccine	65.1	67.0	67.0	68.5
Ease of getting needed care and seeing specialists	83.8	84.7 ^a	84.8 ^a	85.9 ^b
Getting appointments and care quickly	73.8	75.1 ^a	74.1	76.7 ^{ab}
Overall rating of health care quality	83.9	85.5 ^a	84.6	86.1 ^{ab}
Overall rating of plan	83.3	85.7 ^a	81.8	84.2 ^{ab}

Note: PPO (preferred provider organization), HEDIS[®] (Healthcare Effectiveness Data and Information Set, a registered trademark of the National Committee for Quality Assurance), HOS (Health Outcomes Survey), CAHPS[®] (Consumer Assessment of Healthcare Providers and Systems, a registered trademark of the Agency for Healthcare Research and Quality). MA plan types not included in the data are regional PPOs, private fee-for-service plans, continuing care retirement community plans, and employer-directed plans. Cost-reimbursed HMO plan results are included. HEDIS[®] administrative measures are calculated using administrative data, such as claims, encounter data, pharmacy data, and certain electronic records; hybrid measures involve sampling medical records to determine a rate.

^a Statistically significant difference in performance between 2010 and 2011 on this measure for this plan type ($p < .05$).

^b Statistically significant difference in performance in 2011 between HMO and PPO results ($p < .05$).

^c PPO results not reported for hybrid measures for 2010 because it was the first year in which PPOs were able to use medical record review to report rates for such measures. For the colorectal cancer screening measure, CMS specifically excludes PPO results in determining star thresholds for plans because of the specification of the measure, which includes a nine-year look-back period to confirm whether a person has received a colonoscopy.

^d Results shown for HEDIS[®] measures taken from HOS (the three measures listed) include scores for plans not reporting other HEDIS[®] data in 2010. Results may therefore differ from those shown in other MedPAC reporting of these scores.

Source: MedPAC analysis of CMS HEDIS public use files for HEDIS measures, and star ratings data for measures based on HOS and for CAHPS measures.

(Chart continued next page)

Chart 4-6. Medicare Advantage quality measures show improvement between 2010 and 2011 (continued)

- The chart displays the simple averages across all plans in each category (HMOs and local PPOs) for each year.
- HMOs had statistically significant improvement for 12 of the 25 measures shown in the chart, with no measures declining in the 2-year time period. Proportionately, for the categories shown, the greatest improvement was among the patient experience measures and vaccination measure collected through the CAHPS survey (with five of six improving). Half of the HEDIS hybrid measures showed improvement (four out of eight), as did two of three measures collected through HOS. Only one of the six HEDIS administrative measures in the chart showed improvement between 2010 and 2011.
- For local PPOs, the same HEDIS administrative measure that improved among HMOs also improved for local PPOs (monitoring patients taking long-term medications). Four of six measures collected through the CAHPS survey also had statistically significant improvement among local PPOs between 2010 and 2011. Other measures tracked in both 2010 and 2011 showed no statistically significant change.
- Apart from the HEDIS hybrid measures, 9 of 17 measures showed statistically significant differences between HMO averages and local PPO averages, with local PPOs better on six measures and HMOs better on three measures. As of 2010, PPOs began reporting results for hybrid measures using medical record reviews, which PPO plans were not allowed to do prior to 2010. For the hybrid measures, local PPOs are reporting poorer results than HMOs, but this may be because the medical record–based reporting is relatively new for PPOs and also because of the possible difficulty of obtaining medical record information from non-network providers.
- In 2011, CMS began making bonus payments to plans based on their star ratings, giving plans an incentive to improve their performance on quality measures. The measures shown in the above chart include all the measures collected through HEDIS, CAHPS and the HOS that are included in determining a plan's star ratings, except for two measures (recording of body mass index, a hybrid measure that was new as of 2010, and a measure of hospital readmissions, which was introduced in 2011).

Web links. Quality of care in the Medicare program

- Chapters 3, 4, and 6 through 9 of MedPAC's March 2012 Report to the Congress include information on the quality of care provided by inpatient hospitals, physicians and other ambulatory care providers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities.

http://www.medpac.gov/chapters/Mar12_Ch03.pdf
http://medpac.gov/chapters/Mar12_Ch04_CORRECTED.pdf
http://www.medpac.gov/chapters/Mar12_Ch06.pdf
http://www.medpac.gov/chapters/Mar12_Ch07.pdf
http://www.medpac.gov/chapters/Mar12_Ch08.pdf
http://www.medpac.gov/chapters/Mar12_Ch09.pdf

- Chapter 12 of the MedPAC March 2012 Report to the Congress includes information on the quality of care in Medicare Advantage plans.

http://www.medpac.gov/chapters/Mar12_Ch12.pdf

- Chapter 13 of the MedPAC March 2012 Report to the Congress includes information on performance metrics for Medicare Part D plans (prescription drug plans and Medicare Advantage–Prescription Drug plans).

http://www.medpac.gov/chapters/Mar12_Ch13.pdf

- Chapter 6 of the MedPAC March 2010 Report to the Congress includes a set of recommendations on comparing the quality of care between Medicare fee-for-service and Medicare Advantage and among Medicare Advantage plans.

http://www.medpac.gov/chapters/Mar10_Ch06.pdf

- Chapter 4 of the MedPAC June 2007 Report to the Congress discusses policy options to improve the quality of home health services, and Chapter 8 of the same report provides information on the quality of care provided by skilled nursing facilities.

http://www.medpac.gov/chapters/Jun07_Ch04.pdf
http://www.medpac.gov/chapters/Jun07_Ch08.pdf

- Chapter 4 of the MedPAC March 2005 Report to the Congress outlines strategies to improve care through pay-for-performance incentives and information technology.

http://www.medpac.gov/publications/congressional_reports/Mar05_Ch04.pdf

- The CMS website provides information on several of the Medicare quality and value-based purchasing initiatives.

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html?redirect=/QualityInitiativesGenInfo/>

- Medicare provides public comparative information on selected quality measures for hospital, nursing facility, home health agency, and dialysis facilities on its consumer website.

Hospital Compare: <http://www.hospitalcompare.hhs.gov/hospital-search.aspx>

Nursing Home Compare: <http://www.medicare.gov/NHCompare/Home.asp>

Home Health Compare: <http://www.medicare.gov/HomeHealthCompare/search.aspx>

Dialysis Facility Compare: <http://www.medicare.gov/Dialysis/Home.asp>

- CMS makes available downloadable databases of the quality measures and other information underlying the four provider comparison databases cited above.

<http://www.medicare.gov/Download/DownloadDB.asp>

- Medicare Advantage plan quality measures are available through a Medicare consumer website (the Medicare Plan Finder) that makes plan-to-plan comparisons within a specified geographic area, including comparisons with Medicare fee-for-service results on certain measures.

<https://www.medicare.gov/find-a-plan/questions/home.aspx>

- CMS makes available a downloadable database of the Medicare Advantage plan quality measures underlying the Medicare Plan Finder and the star ratings of plans.

<http://www.medicare.gov/Download/DownloadDB.asp> (select “Plan Ratings Data” from the drop-down menu)

- Current and past editions of the National Committee for Quality Assurance (NCQA) publication *The State of Health Care Quality* are available from the NCQA website.

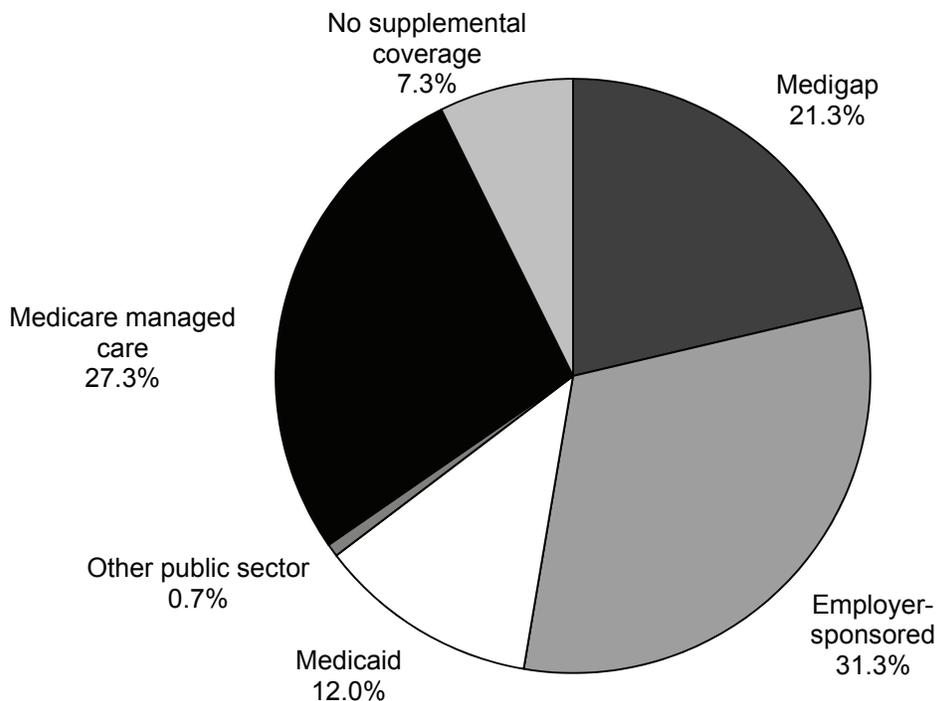
<http://www.ncqa.org/tabid/836/Default.aspx>

SECTION

5

**Medicare beneficiary and
other payer financial liability**

Chart 5-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2009



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2009. They could have had coverage in other categories during 2009. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2009 or who had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. About 93 percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- About 53 percent have private-sector supplemental coverage such as medigap (about 21 percent) or employer-sponsored retiree coverage (about 31 percent).
- About 13 percent have public-sector supplemental coverage, primarily Medicaid.
- Twenty-seven percent participate in Medicare managed care. This care includes Medicare Advantage, cost, and health care prepayment plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often add to it.

Chart 5-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2009

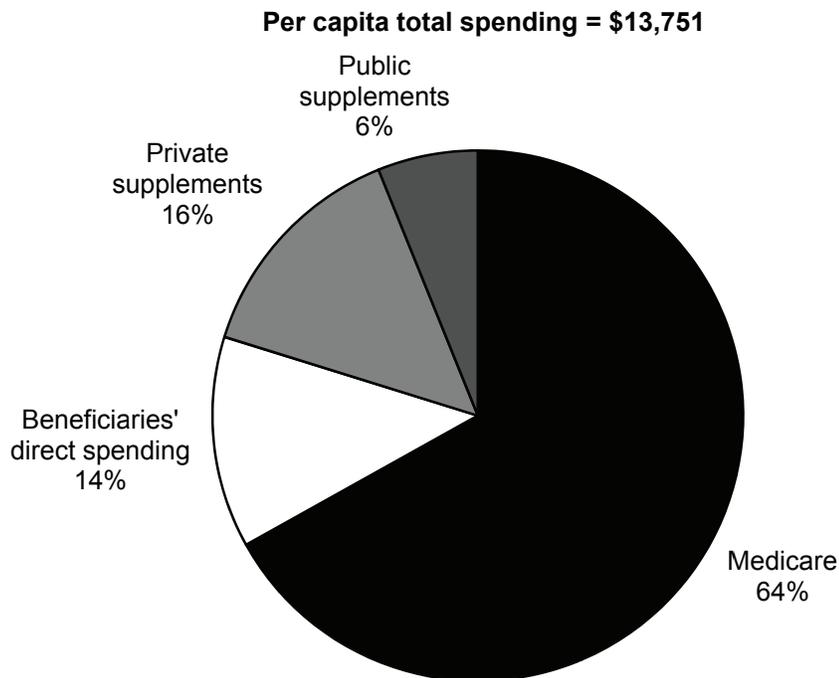
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	40,197	31%	21%	12%	27%	1%	7%
Age							
Under 65	6,047	15	4	41	21	2	17
65–69	9,260	37	20	8	27	0	8
70–74	8,142	32	24	7	31	1	5
75–79	6,512	32	25	7	31	1	4
80–84	5,281	34	26	6	29	1	4
85+	4,954	35	29	7	24	0	4
Income status							
Below poverty	6,139	11	12	44	25	0	7
100% to 125% of poverty	3,636	12	16	29	30	1	12
125% to 200% of poverty	7,993	23	21	11	32	2	12
200% to 400% of poverty	12,565	39	24	1	29	0	6
Over 400% of poverty	9,807	48	26	1	22	0	3
Eligibility status							
Aged	33,905	34	24	7	29	1	6
Disabled	5,848	15	4	40	21	2	17
ESRD	398	17	24	43	9	1	6
Residence							
Urban	30,639	31	20	11	31	1	6
Rural	9,546	31	27	16	14	1	11
Sex							
Male	17,970	33	19	12	26	1	9
Female	22,227	30	23	12	28	1	6
Health status							
Excellent/very good	17,118	36	25	5	27	0	5
Good/fair	19,896	29	19	15	29	1	8
Poor	2,859	19	14	32	22	2	12

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2009. They could have had coverage in other categories during 2009. Medicare managed care includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. In 2009, poverty was defined as \$10,289 for people living alone and \$12,982 for married couples. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs). "Rural" indicates beneficiaries living outside MSAs. Analysis includes beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2009 or who had Medicare as a secondary payer. Number of beneficiaries differs among boldface categories because we excluded beneficiaries with missing values. Numbers may not sum due to rounding.

Source: MedPAC analysis of 2009 Medicare Current Beneficiary Survey, Cost and Use file.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are above age 64, are higher income (above 200 percent of poverty), are eligible due to age, and report better than poor health.
- Medigap is most common among those who are age 70 or older, are middle or higher income (above 125 percent of poverty), are eligible due to age or ESRD, are rural dwelling, are female, and report excellent or very good health.
- Medicaid coverage is most common among those who are under age 65, are low income (below 125 percent of poverty), are eligible due to disability or ESRD, are rural dwelling, and report poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, have income below 200 percent of poverty, are eligible due to disability, are rural dwelling, are male, and report poor health.

Chart 5-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2009

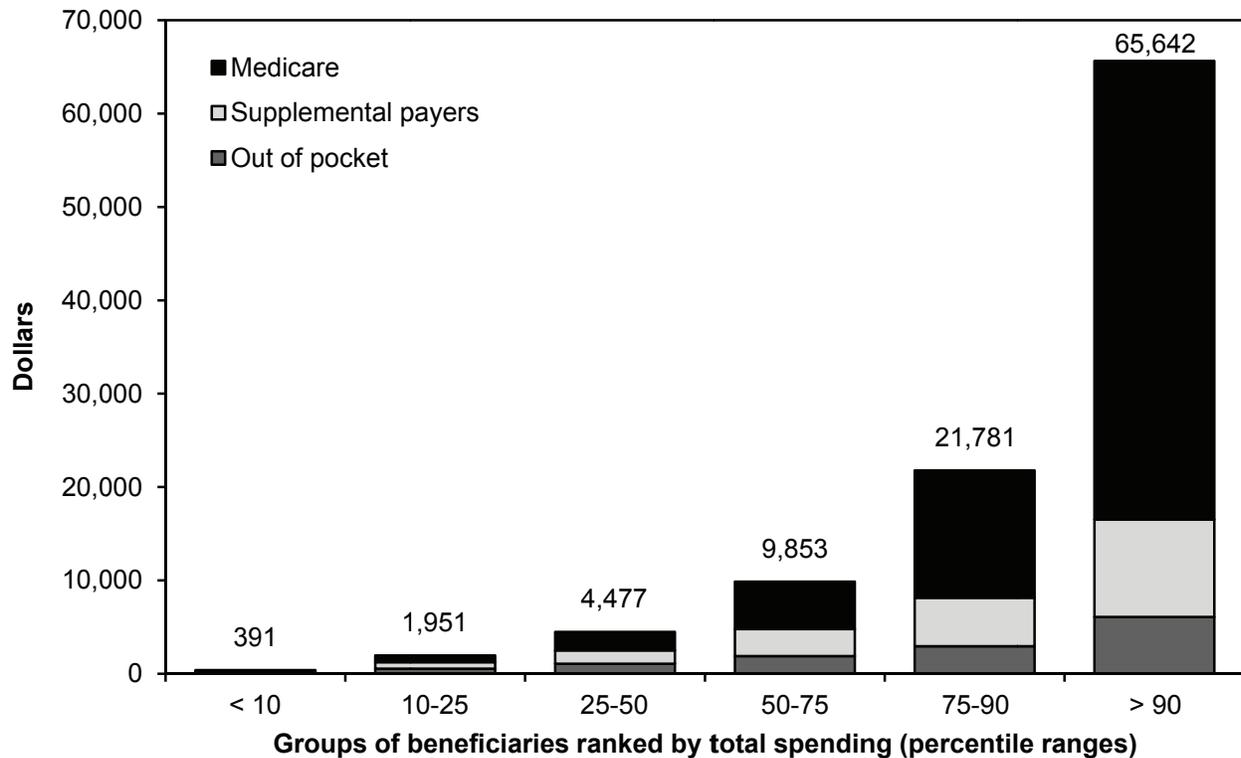


Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services, but not supplemental premiums. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- Among FFS beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' direct spending, as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averaged \$13,751 in 2009. Medicare is the largest source of payment; it pays 64 percent of the health care costs for FFS beneficiaries living in the community, an average of \$8,845 per beneficiary. The level of Medicare spending in this chart differs from the level in Chart 2-1 because this chart excludes beneficiaries in Medicare Advantage and those living in institutions, while Chart 2-1 represents all Medicare beneficiaries.
- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid 16 percent of beneficiaries' costs, an average of \$2,259 per beneficiary.
- Beneficiaries paid 14 percent of their health care costs out of pocket, an average of \$1,877 per beneficiary.
- Public sources of supplemental coverage—primarily Medicaid—paid 6 percent of beneficiaries' health care costs, an average of \$769 per beneficiary.

Chart 5-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2009

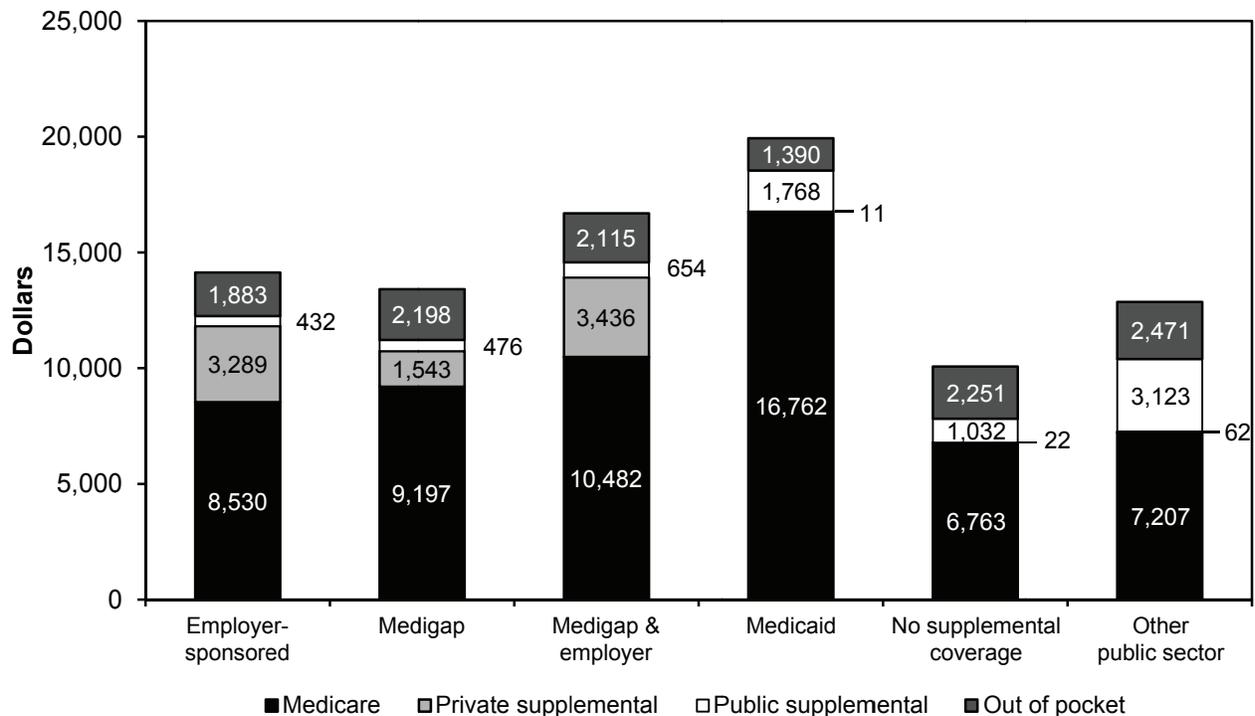


Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. Out-of-pocket spending includes Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- Total spending on health care services varies dramatically among FFS beneficiaries living in the community. Per capita spending for the 10 percent of beneficiaries with the highest total spending averages \$65,642. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averages \$391.
- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' out-of-pocket spending is a smaller percentage as total spending increases. For example, Medicare pays 64 percent of total spending for all beneficiaries but pays 75 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' out-of-pocket spending covers 14 percent of total spending for all beneficiaries, but only 9 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 5-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2009

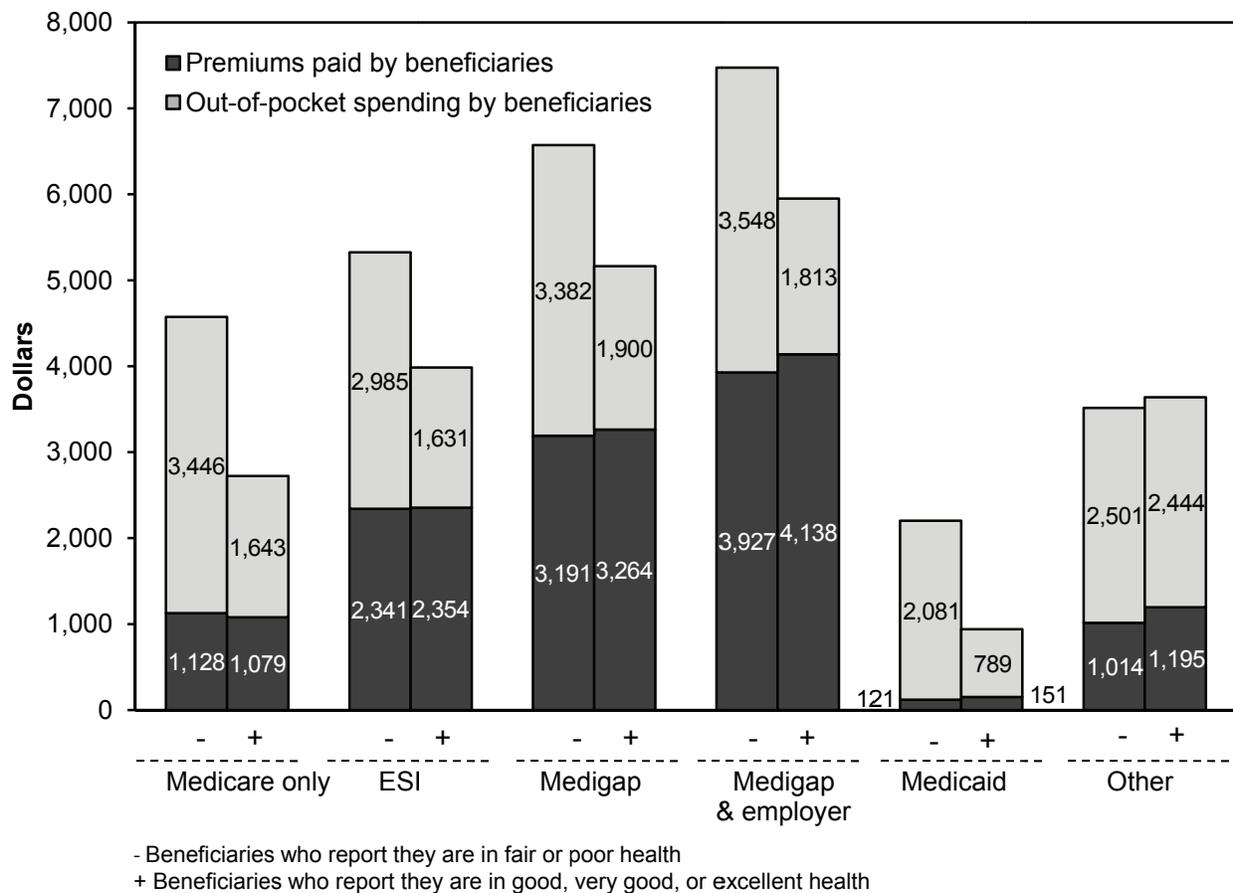


Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2009. They could have had coverage in other categories during 2009. "Other public sector" includes federal and state programs not included in the other categories. "Private supplemental" includes employer-sponsored plans and individually purchased coverage. "Public supplemental" includes Medicaid, Department of Veterans Affairs, and other public coverage. Analysis excludes beneficiaries who are not in FFS Medicare or live in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2009 or had Medicare as a second payer. Out-of-pocket spending includes Medicare cost sharing and noncovered services, but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009

- The level of total spending (defined as beneficiaries' out-of-pocket spending, as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among FFS beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, 98 percent higher than those with no supplemental coverage.
- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with employer-sponsored, medigap plus employer, Medicaid, and other public, supplemental coverage coverage—public and private combined—is the second largest source of payment. Among those who have only medigap, supplemental coverage and out of pocket are about equal. Among those who have Medicare-only coverage, beneficiaries' out-of-pocket spending is the second largest source of payment.

Chart 5-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2009



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2009.

- This diagram illustrates out-of-pocket spending on services and premiums by beneficiaries' supplemental insurance and health status. For example, beneficiaries who have only traditional Medicare coverage (Medicare only) and report fair or poor health had an average of \$1,128 in out-of-pocket spending on premiums and \$3,446 on services. Those who have Medicare-only coverage and report good, very good, or excellent health had an average of \$1,079 in out-of-pocket spending on premiums and \$1,643 on services.
- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health regardless of the type of coverage they have to supplement Medicare.
- Despite having supplemental coverage, beneficiaries who have ESI or medigap have out-of-pocket spending that is comparable to or more than those who have only coverage under traditional Medicare (Medicare only). This result likely reflects the fact that beneficiaries who have ESI or medigap have higher incomes and are likely to have stronger preferences for health care.
- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with medigap, out-of-pocket spending generally reflects the premiums and costs of services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for Medicare noncovered services than those with medigap, but may pay more in Medicare deductibles and cost sharing.

Web links. Medicare beneficiary and other payer financial liability

- Chapter 1 of the MedPAC March 2012 Report to the Congress provides more information on Medicare program spending.

http://www.medpac.gov/chapters/Mar12_ch01.pdf

- Chapter 1 of the MedPAC March 2011 Report to the Congress provides more information on Medicare program spending.

http://www.medpac.gov/chapters/Mar11_ch01.pdf

- Chapter 1 of the MedPAC March 2010 Report to the Congress provides more information on Medicare program spending.

http://www.medpac.gov/chapters/Mar10_ch01.pdf

- Chapter 1 of the MedPAC June 2012 Report to the Congress discusses benefit design in fee-for-service Medicare.

http://www.medpac.gov/chapters/Jun12_ch01.pdf

- Chapter 3 of the MedPAC June 2011 Report to the Congress discusses beneficiaries' supplemental coverage, cost sharing, and health care use, as well as program spending.

http://medpac.gov/chapters/Jun11_ch03.pdf

- Chapter 2 of the MedPAC June 2010 Report to the Congress discusses the effect supplemental coverage has on beneficiaries' cost sharing, their health care use, and program spending.

http://www.medpac.gov/chapters/Jun10_ch02.pdf

- Appendix B of the MedPAC June 2004 Report to the Congress and Chapter 1 of the MedPAC June 2002 Report to the Congress provide more information on Medicare beneficiary and other payer financial liability.

http://www.medpac.gov/publications/congressional_reports/June04_AppB.pdf

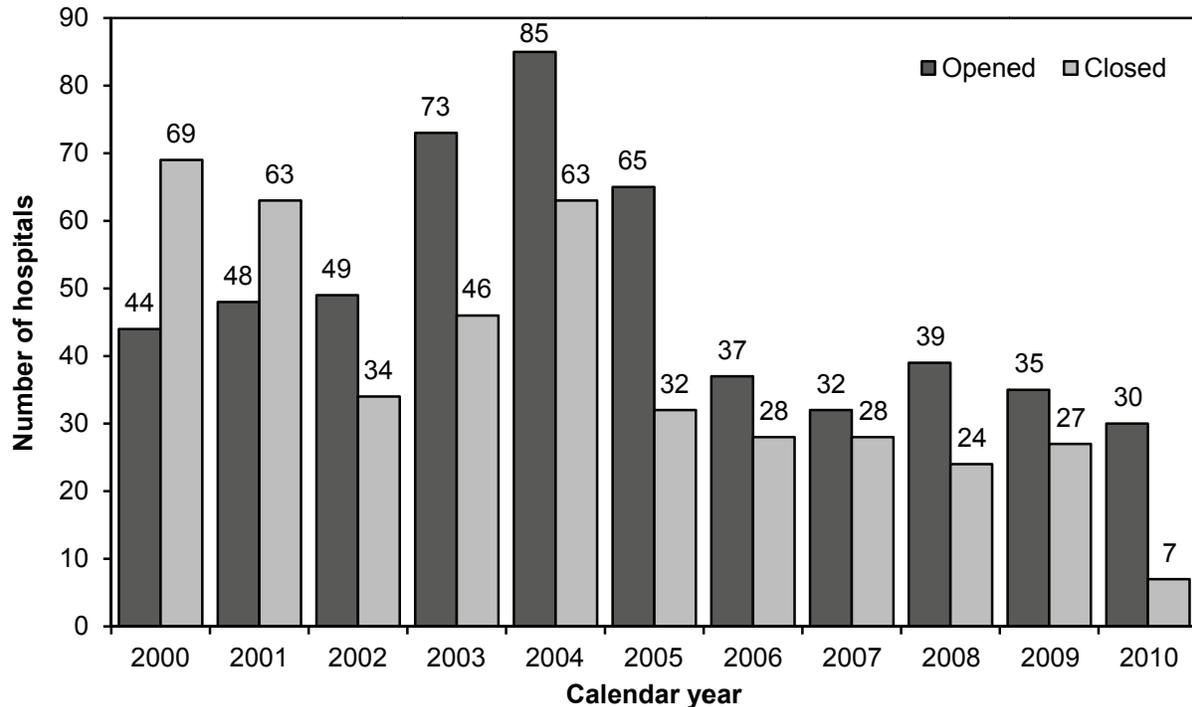
http://www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf

SECTION

6

Acute inpatient services
Short-term hospitals
Specialty psychiatric facilities

Chart 6-1. Annual changes in number of acute care hospitals participating in the Medicare program, 2000–2010



Note: Openings and closures exclude hospitals converting to critical access hospitals, and beginning in 2006 hospitals converting to long-term care hospitals were also excluded. Closures include voluntary and involuntary terminations.

Source: MedPAC analysis of the Provider of Service file from CMS.

- The number of hospital openings exceeded the number of closures for the eighth consecutive year. In 2010, 30 acute care hospitals began participating in the Medicare program and 7 terminated it.
- In 2010, 4,824 acute care hospitals (including critical access hospitals) participated in Medicare.

Chart 6-2. Percent change in hospital employment, by occupation, 2008–2010

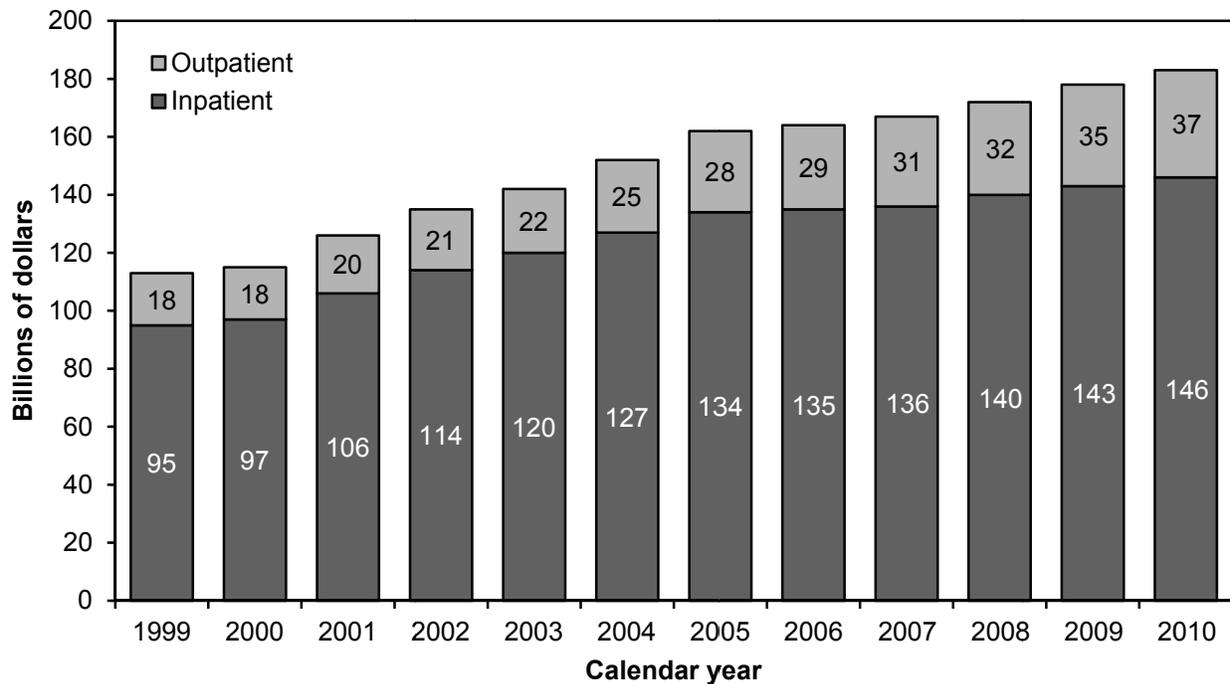
	Total U.S. employment (May 2008)	Total U.S. employment (May 2010)	Percent change in total employment (2008–2010)
All hospital occupations	5,096,190	5,159,860	1.2%
Physician assistant	16,820	18,710	11.2
Diagnostic sonographer	28,930	31,830	10.0
Computer and math science	52,180	56,820	8.9
Management	175,390	189,430	8.0
Life, physical, and social science (science)	25,550	27,160	6.3
Pharmacist	55,530	58,680	5.7
Business and finance	92,160	96,960	5.2
Registered nurse	1,458,520	1,521,400	4.3
Radiology technician	125,640	129,750	3.3
HC clinicians and technical	2,712,350	2,782,610	2.6
Internists	8,100	8,280	2.2
Surgeons	5,730	5,830	1.7
LPN or LVN	163,360	145,130	-11.2

Note: LPN (licensed practical nurse), LVN (licensed vocational nurse).

Source: MedPAC analysis of Bureau of Labor Statistics, Occupational Employment Statistics data set as of September 2011.

- In general, changes reported here continue trends we observed last year.
- From May 2008 to May 2010, hospital employment increased 1.2 percent. By the end of this period, the hospital industry employed nearly 5.2 million individuals.
- The number of physician assistants employed by hospitals increased more rapidly than any other occupation from 2008 to 2010, at 11.2 percent. Growth was also well above average for diagnostic sonographers, at 10.0 percent.
- The number of computer and math science staff at hospitals increased rapidly from May 2008 to May 2010, at 8.9 percent. Growth of this occupation may reflect hospitals' implementation of electronic health record systems.
- LPNs and LVNs were among the few occupations to experience a decline in the number of individuals employed by hospitals from 2008 to 2010, declining by 11.2 percent. During the same time period, the number of registered nurses employed by hospitals increased 4.3 percent (62,880 registered nurses), suggesting a shift toward employing nurses with a higher level of training.

Chart 6-3. Growth in Medicare’s FFS payments for hospital inpatient and outpatient services, 1999–2010



Note: FFS (fee-for-service). Analysis includes inpatient services covered by the acute inpatient prospective payment system (PPS); psychiatric, rehabilitation, long-term care, cancer, and children’s hospitals and units; outpatient services covered by the outpatient PPS; and other outpatient services. Payments include program outlays and beneficiary cost sharing. The growth in spending was slowed in 2006 by large increases in the number of Medicare Advantage enrollees, who are not included in these aggregate totals.

Source: CMS, Office of the Actuary.

- Aggregate Medicare FFS inpatient spending was \$146 billion and outpatient spending was \$37 billion in 2010. From 2009 to 2010, inpatient spending increased about 2 percent, while outpatient spending increased about 6 percent.
- A freeze in inpatient payment rates in the Balanced Budget Act of 1997 reduced inpatient spending growth from 1999 to 2000. Spending increased substantially between 2001 and 2004, but reverted to relatively slow growth from 2005 to 2007 because a large number of beneficiaries switched from traditional FFS Medicare to the Medicare Advantage program. More rapid payment growth resumed in 2008 for inpatient and outpatient services.
- Outpatient spending has increased as a share of total hospital-based spending in the last 12 years. In 1999, outpatient spending accounted for almost 16 percent of all hospital spending; in 2010, outpatient spending grew to more than 20 percent of total hospital spending.
- Outpatient spending per FFS beneficiary was about \$1,181 in 2010, up from approximately \$590 in 1999, an increase of over 100 percent.

Chart 6-4. Proportion of Medicare acute care hospital inpatient discharges by hospital group, 2010

Hospital group	Hospitals		Medicare discharges	
	Number	Share of total	Number (thousands)	Share of total
All PPS hospitals and CAHs	4,636	100.0%	10,721	100.0%
PPS hospitals	3,332	71.9	10,331	96.4
Urban	2,410	52.0	8,913	83.1
Large urban	1,319	28.5	4,903	45.7
Other urban	1,091	23.5	4,010	37.4
Rural (excluding CAHs)	922	19.9	1,418	13.2
Rural referral	123	2.7	384	3.6
Sole community	385	8.3	588	5.5
Medicare dependent	195	4.2	208	1.9
Other rural <50 beds	91	2.0	48	0.5
Other rural ≥50 beds	128	2.8	189	1.8
Voluntary	1,945	42.0	7,356	68.6
Proprietary	818	17.6	1,651	15.4
Government	569	12.3	1,323	12.3
Major teaching	268	5.8	1,584	14.8
Other teaching	751	16.2	3,730	34.8
Nonteaching	2,313	49.9	5,017	46.8
CAHs	1,304	28.1	390	3.6

Note: PPS (prospective payment system), CAH (critical access hospital). Analysis includes all hospitals covered by Medicare's inpatient PPS along with CAHs. Maryland hospitals are excluded. Large urban areas have populations of more than 1 million. Major teaching hospitals are defined by a ratio of interns and residents to beds of at least 0.25. Other teaching hospitals have a ratio below 0.25. Data are limited to providers with complete cost reports in the CMS database. See Chart 6-24 for more information about CAHs. Numbers may not sum to totals due to rounding. Sample of hospitals limited to those with complete hospital cost reports in 2010.

Source: MedPAC analysis of PPS impact files and Medicare cost report data from CMS.

- In 2010, 3,332 hospitals provided 10.3 million discharges under Medicare's acute inpatient prospective payment system (IPPS) and 1,304 CAHs provided about 400,000 discharges. The number of PPS discharges declined from 2009 to 2010, primarily due to a shift in services from the inpatient to the outpatient setting.
- Approximately 15 percent of all hospitals are covered by three special payment provisions (rural referral centers (RRC), sole community hospitals (SCHs), and small rural Medicare-dependent hospitals (MDHs)) intended to help rural facilities that are not CAHs; these facilities account for more than 11 percent of all discharges. The number of these hospitals increased approximately 1 percent from 2009 to 2010.
- About 90 percent of rural hospitals were CAHs, SCHs, MDHs, or RRCs in 2010. Collectively, these four types of hospitals provide 87 percent of all rural discharges.

Chart 6-5. Major diagnostic categories with highest volume, fiscal year 2010

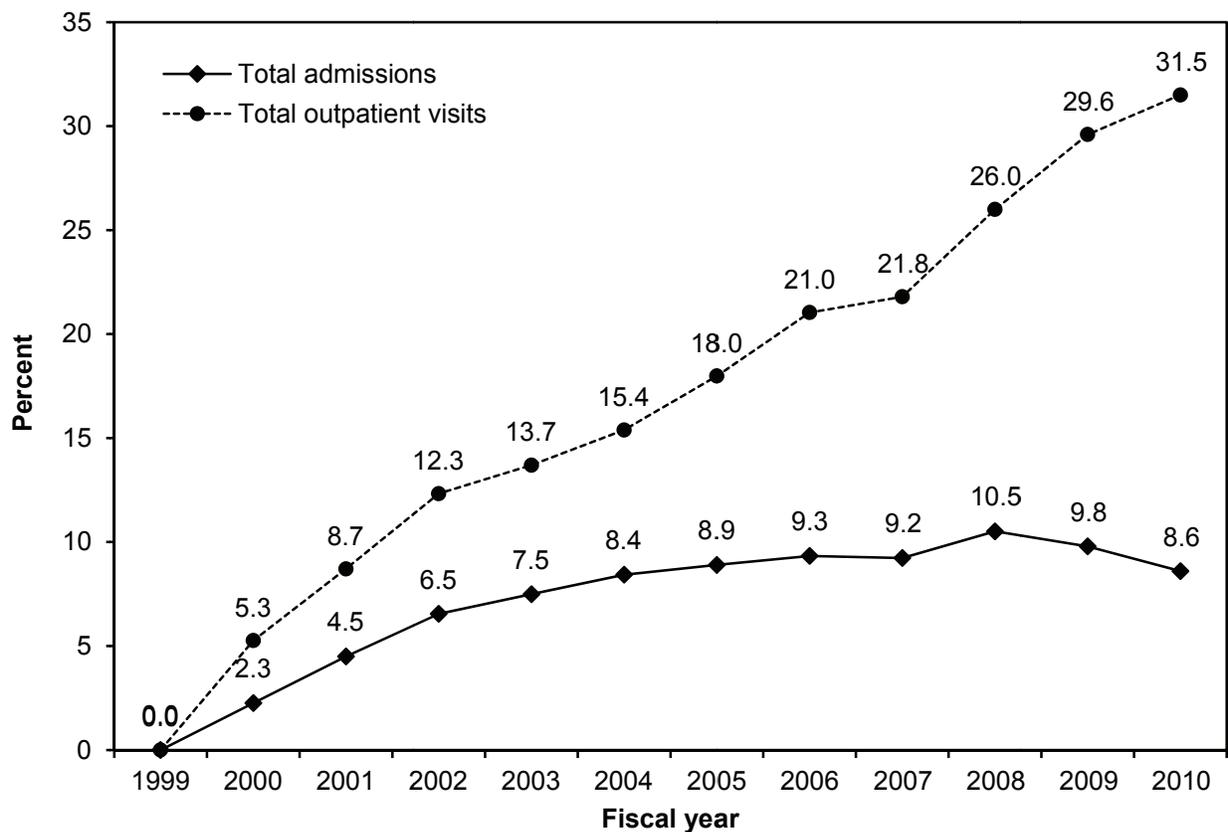
MDC number	MDC name	Share of all discharges	Share of medical discharges	Share of surgical discharges
5	Circulatory system	24%	23%	26%
4	Respiratory system	15	19	3
8	Musculoskeletal system and connective tissue	12	4	35
6	Digestive system	11	11	10
1	Nervous system	8	9	5
11	Kidney and urinary tract	7	8	4
18	Infectious and parasitic diseases	5	6	2
10	Endocrine, nutritional, and metabolic diseases and disorders	4	5	2
7	Hepatobiliary system and pancreas	3	3	4
9	Skin, subcutaneous tissue, and breast	3	3	2
	Total	92	91	93

Note: MDC (major diagnostic category). Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of MedPAR data from CMS.

- In fiscal year 2010, 10 major diagnostic categories accounted for 92 percent of all discharges at hospitals paid under the acute inpatient prospective payment system.
- Circulatory system cases accounted for about one-quarter of medical and surgical cases.
- Respiratory system cases accounted for nearly 20 percent of medical discharges.
- Musculoskeletal system cases accounted for 35 percent of surgical discharges.

Chart 6-6. Cumulative change in total admissions and total outpatient visits, 1999–2010

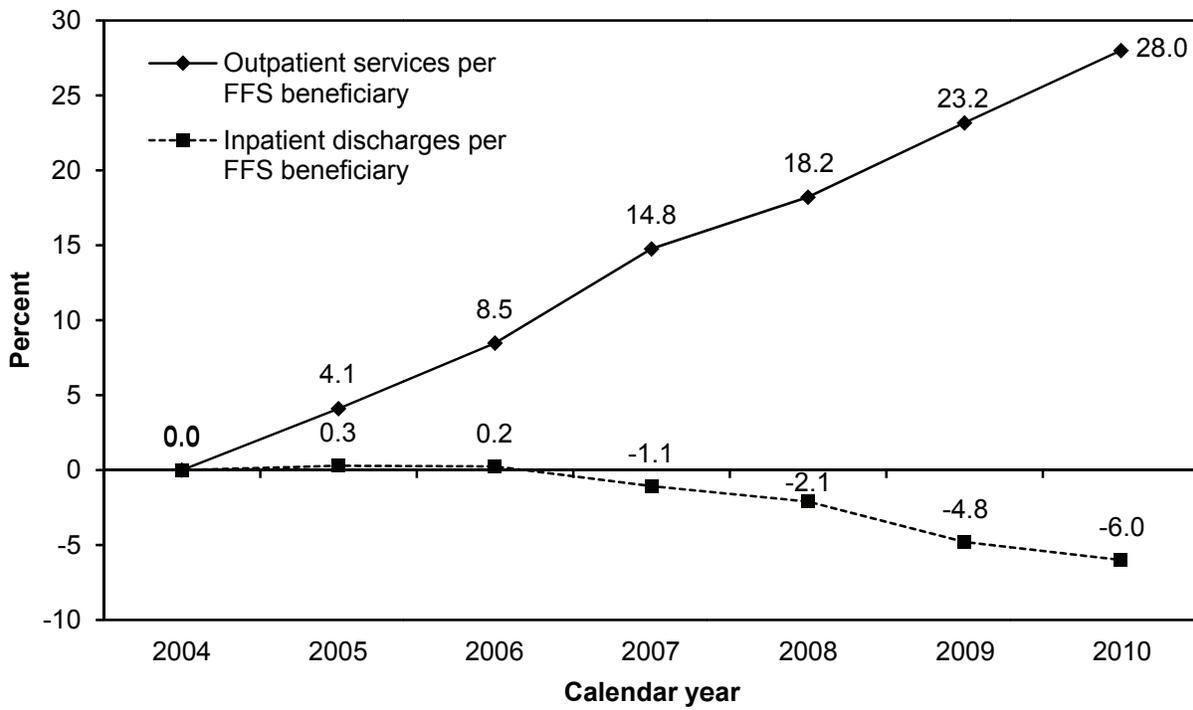


Note: Cumulative change is the total percent increase from 1999 through 2010. Data are admissions (all payers) to and outpatient visits at about 5,000 community hospitals.

Source: American Hospital Association, AHA Hospital Statistics.

- Hospital outpatient service use grew much more rapidly from 1999 to 2010 than inpatient service use. Total hospital outpatient visits increased about 31 percent from 1999 to 2010. Total admissions grew by over 10 percent between 1999 and 2008, but have declined since 2008.
- There were 651 million outpatient visits and approximately 35 million admissions to community hospitals in 2010.
- The cumulative percent change in total outpatient visits increased by nearly 2 percentage points from 2009 to 2010, or nearly 10 million visits.
- The cumulative percent change in inpatient admissions decreased by 1.2 percentage points from 2009 to 2010, or nearly 380,000 admissions. It was the largest single-year decrease in the last 10 years. Inpatient admission declined slightly less from 2008 to 2009.

Chart 6-7. Cumulative change in Medicare outpatient services and inpatient discharges per FFS beneficiary, 2004–2010

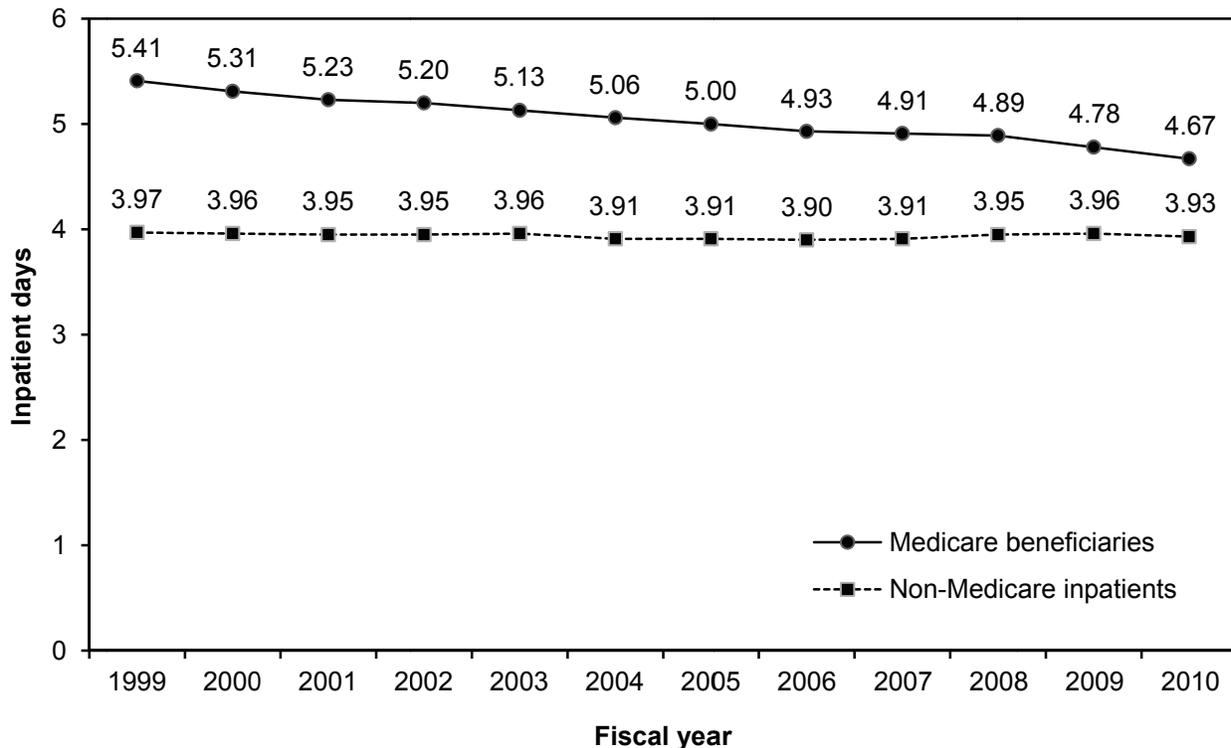


Note: FFS (fee-for-service). Data are for short-term general and surgical hospitals, including critical access and children's hospitals.

Source: MedPAC analysis of MedPAR and hospital outpatient claims data from CMS.

- From 2004 to 2010, the number of Medicare inpatient discharges per FFS beneficiary declined 6.0 percent. From 2004 to 2006, inpatient volume per beneficiary was relatively flat, but beginning in 2007, the volume of discharges began to decline.
- From 2004 to 2010, the number of outpatient services per FFS beneficiary increased 28 percent.
- Together these two trends suggest a shift in services from the inpatient to the outpatient setting.

Chart 6-8. Trends in Medicare inpatient and non-Medicare inpatient length of stay, 1999–2010

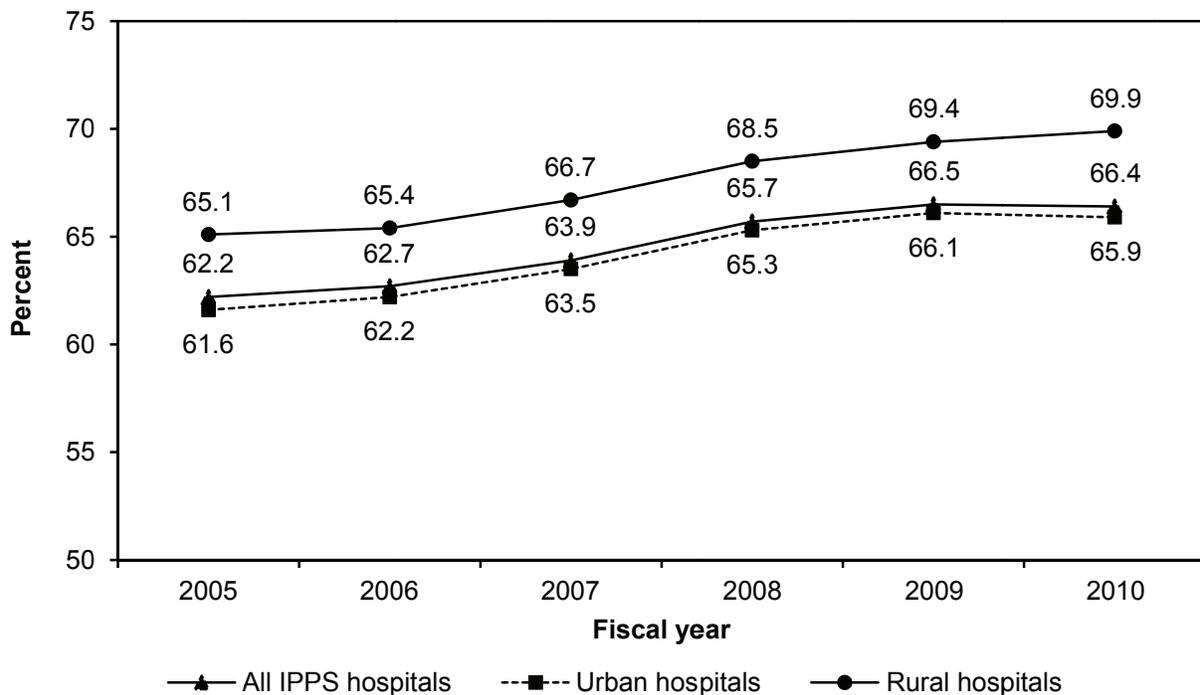


Note: Length of stay is calculated from discharges and patient days for more than 3,000 hospitals covered by the acute inpatient prospective payment system. Excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Average length of inpatient stay for Medicare beneficiaries was nearly 1 day longer than for non-Medicare inpatients in 2010.
- Average length of inpatient stay for Medicare beneficiaries fell nearly 14 percent, from 5.41 days in 1999 to 4.67 days in 2010. From 1999 to 2010, Medicare length of stay declined at an average annual rate of approximately 1.3 percent. Over the course of the decade, the decline was most rapid between 2008 and 2010, declining at more than 2 percent per year.
- Average length of stay for all non-Medicare inpatients remained nearly unchanged at 3.93 days between 1999 and 2010.

Chart 6-9. Share of inpatient admissions preceded by emergency department visit, 2005–2010

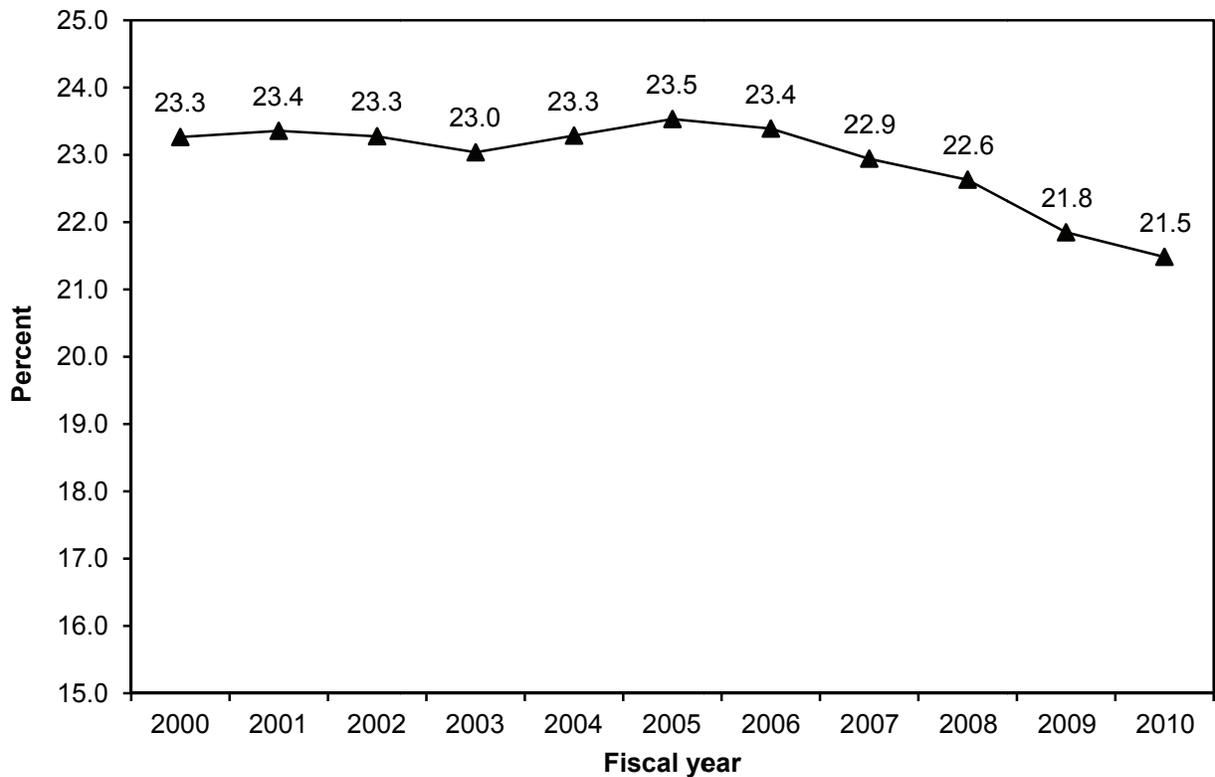


Note: IPPS (inpatient prospective payment system).

Source: MedPAC analysis of MedPAR data from CMS.

- The share of inpatient admissions preceded by an emergency department visit increased from approximately 62 percent to 66 percent from 2005 to 2010, an increase of approximately 4 percentage points.
- The share of inpatient admissions preceded by an emergency department visit is consistently higher for rural hospitals than urban hospitals, but increased at approximately same rate from 2005 to 2010. In 2010, approximately 70 percent of inpatient admissions provided at rural hospitals were preceded by an emergency department visit. By contrast, approximately 66 percent of inpatient admissions provided at urban hospitals were preceded by an emergency department visit. The share of inpatient admissions preceded by an emergency department visit increased between 4 and 5 percentage points for both rural and urban hospitals.
- The share of inpatient admissions preceded by an emergency department visit increased faster between 2005 and 2010 at nonprofit hospitals than at for-profit hospitals (not shown in Chart 6-9). For nonprofit hospitals, the share of inpatient admissions preceded by an emergency department visit increased from 63 percent to 67 percent from 2005 to 2010. For for-profit hospitals, the share of inpatient admissions preceded by an emergency department visit increased from 62 percent to 64 percent from 2005 to 2010. Therefore, as nonprofit hospitals experienced a 4 percentage point increase, for-profit hospitals experienced only a 2 percentage point increase.

Chart 6-10. Share of Medicare Part A beneficiaries with at least one hospitalization, 2000–2010

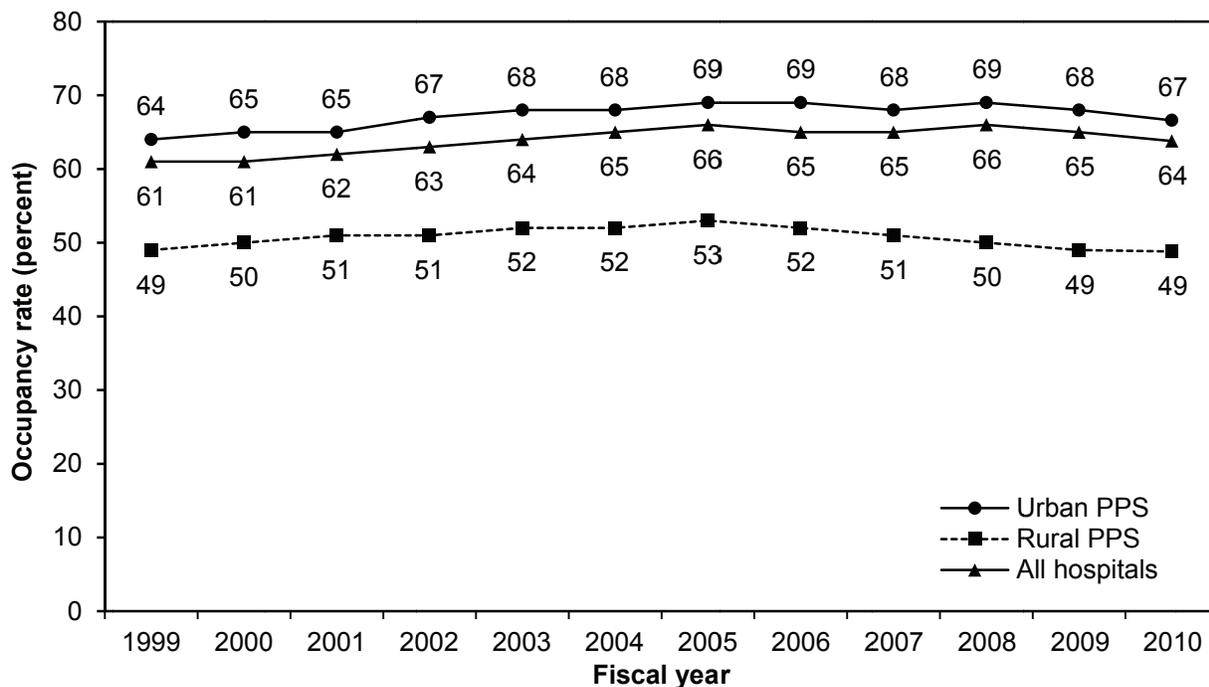


Note: Analysis excludes Medicare Advantage claims and claims for non–inpatient prospective payment system hospitals, such as critical access hospitals and hospitals located in Maryland.

Source: MedPAC analysis of MedPAR data from CMS.

- The share of Medicare beneficiaries with Part A coverage who had at least one inpatient hospitalization in a given year declined by 2 percentage points from 2005 to 2010. In 2010, 21.5 percent of Medicare beneficiaries had at least one inpatient stay covered under Part A.
- Since 2005, the decline in the share of Medicare Part A beneficiaries using inpatient hospital care may be in part attributable to the rapid shift of surgical cases from the inpatient setting to the outpatient setting. In the inpatient setting, the number of surgical cases per beneficiary declined more rapidly than medical cases from 2005 to 2010, at 12.7 percent and 5.6 percent, respectively.

Chart 6-11. Hospital occupancy rates, 1999–2010



Note: PPS (prospective payment system). Hospital occupancy rate is measured as total inpatient days as a percent of total available bed days in the hospital over the reporting period. Bed days available are based on beds that are set up and staffed for inpatient service (i.e., the units are open and operating), but the beds may not be staffed for a full patient load in each unit on a given day. Hospitals' group designations for the entire 1999–2010 period are based on their status at the end of 2010.

Source: MedPAC analysis of data from the American Hospital Association Annual Survey of Hospitals.

- In the aggregate, hospital occupancy rates have been relatively stable over the last decade, but have edged down slightly in more recent years. In 2010, occupancy rates were 64 percent across all hospitals, returning to levels observed prior to 2004.
- Occupancy rates are generally higher for urban than rural hospitals. In 2010, occupancy rates stood at 67 percent for urban hospitals and 49 percent for rural hospitals, an 18 percentage point difference.
- Occupancy rates may understate overall facility occupancy levels because they do not include outpatient observation cases, which are often placed in beds counted as inpatient bed space.

Chart 6-12. Medicare inpatient payments, by source and hospital group, 2010

Hospital group	Percent of total payments					Total payments (millions)
	Base	IME	DSH	Outlier	Additional rural hospital*	
All hospitals	80.9%	5.0%	9.7%	3.2%	1.3%	\$111,057
Urban	80.5	5.5	10.2	3.5	0.4	99,701
Rural	84.9	0.7	5.2	0.9	8.9	11,356
Large urban	78.6	6.7	10.7	4.0	0.0	57,790
Other urban	82.9	3.9	9.6	2.7	1.0	41,911
Rural referral	89.3	1.1	8.1	1.6	0.0	3,212
SCH (federal rate)	87.1	3.2	8.5	1.1	0.0	1,190
SCH (HSP rate)	76.7	0.1	0.0	0.2	22.9	3,957
Medicare dependent	84.2	0.0	8.2	0.8	6.9	1,428
Other rural <50 beds	91.6	0.2	7.5	0.7	0.0	284
Other rural ≥50 beds	91.2	0.5	7.4	0.9	0.0	1,285
Voluntary	81.8	5.3	8.8	2.9	1.3	79,761
Proprietary	84.3	1.4	11.4	2.3	0.6	15,837
Government	73.0	7.1	12.4	5.7	2.0	15,459
Major teaching	65.8	16.1	12.4	5.6	0.1	25,234
Other teaching	82.9	3.8	9.7	2.8	0.9	40,249
Nonteaching	87.5	0.0	8.1	2.3	2.3	45,574

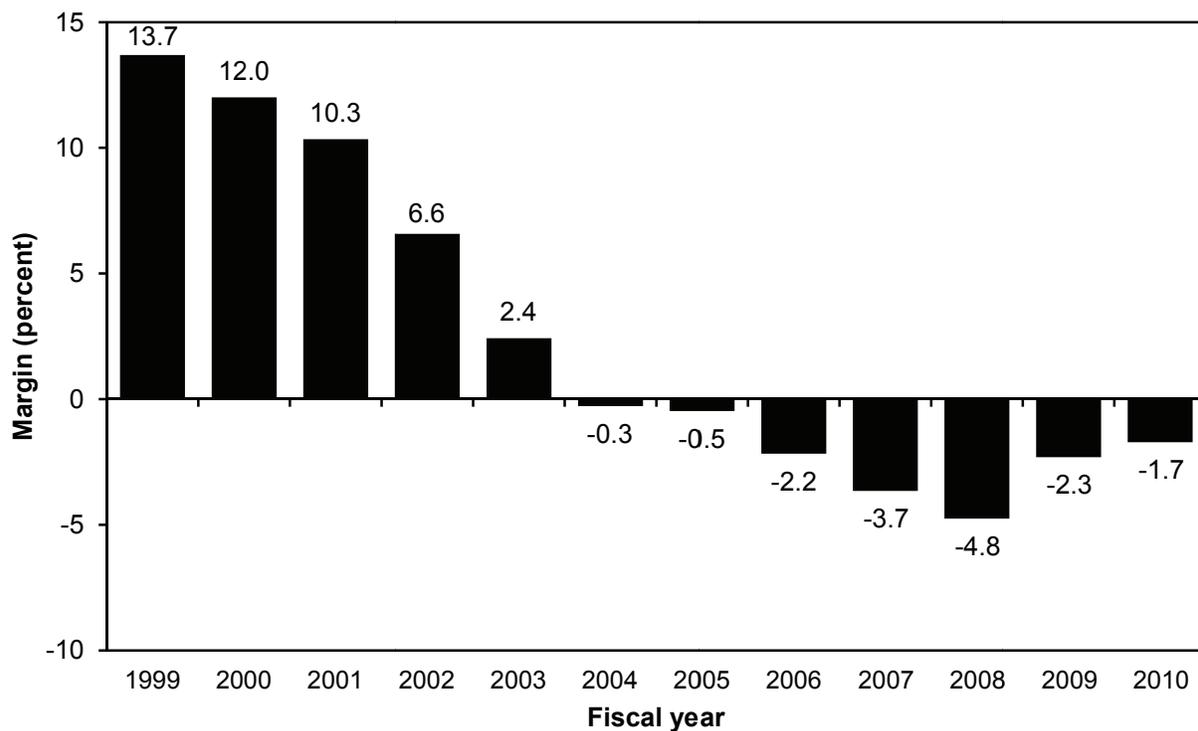
Note: IME (indirect medical education), DSH (disproportionate share), SCH (sole community hospital), HSP (hospital specific payment [rate]). Includes all hospitals covered by Medicare's acute inpatient prospective payment system (PPS). Includes both operating and capital payments but excludes direct graduate medical education payments. Simulated payments reflect 2010 payment rules applied to actual number of cases in 2010. Excludes critical access hospitals and their special payments. Medicare-dependent hospital categories include facilities paid at either the hospital specific rate or the federal rate. Rows may not sum to 100 percent due to rounding.

*Additional rural hospital payments are the total payments made to hospitals beyond the federal base rate. This category includes rural add-on payments such as the SCH add-on, the Medicare-dependent hospital (MDH) add-on, and the low-volume add-on (the enhanced low-volume adjustment did not start until fiscal year 2011). For SCHs paid the hospital specific rate, this category also includes the payments they received indirectly attributable to the costs associated with residency programs, low-income patients, and outlier cases. These SCHs are not eligible for the operating IME, DSH, and outlier policies, while SCHs paid the federal rate are eligible for these three policies. The additional rural hospital payments category does not include wage index adjustments or critical access hospitals' (CAHs') cost-based payments. A few SCHs are located in urban areas.

Source: MedPAC analysis of claims and impact file data from CMS.

- Medicare inpatient payments in 2010 to hospitals covered by the acute inpatient prospective payment system totaled more than \$111 billion. About \$100 billion (90 percent) was paid to hospitals located in urban areas and \$11 billion went to rural hospitals. This figure does not reflect the \$2.7 billion in payments to CAHs for inpatient care. Cost-based reimbursement for CAHs amounts to an increase of approximately \$300 million above the standard IPPS rate.
- Special payments—which include indirect medical education, disproportionate share, and outlier payments as well as additional payments to rural hospitals through the SCH and MDH programs—account for 19 percent of all inpatient payments. This proportion is higher for urban (19.6 percent) than for rural hospitals (15.7 percent).
- Outlier payments accounted for 3.2 percent of total inpatient payments in 2010. The legislative mandate for the level of outlier payments uses a different calculation, displaying outlier payments as a ratio of outlier payments to base payments plus outlier payments. Measured in this way, CMS's outlier share ratio was 4.7 percent in fiscal year 2010, slightly lower than the annual goal of 5.1 percent.

Chart 6-13. Medicare acute inpatient PPS margin, 1999–2010

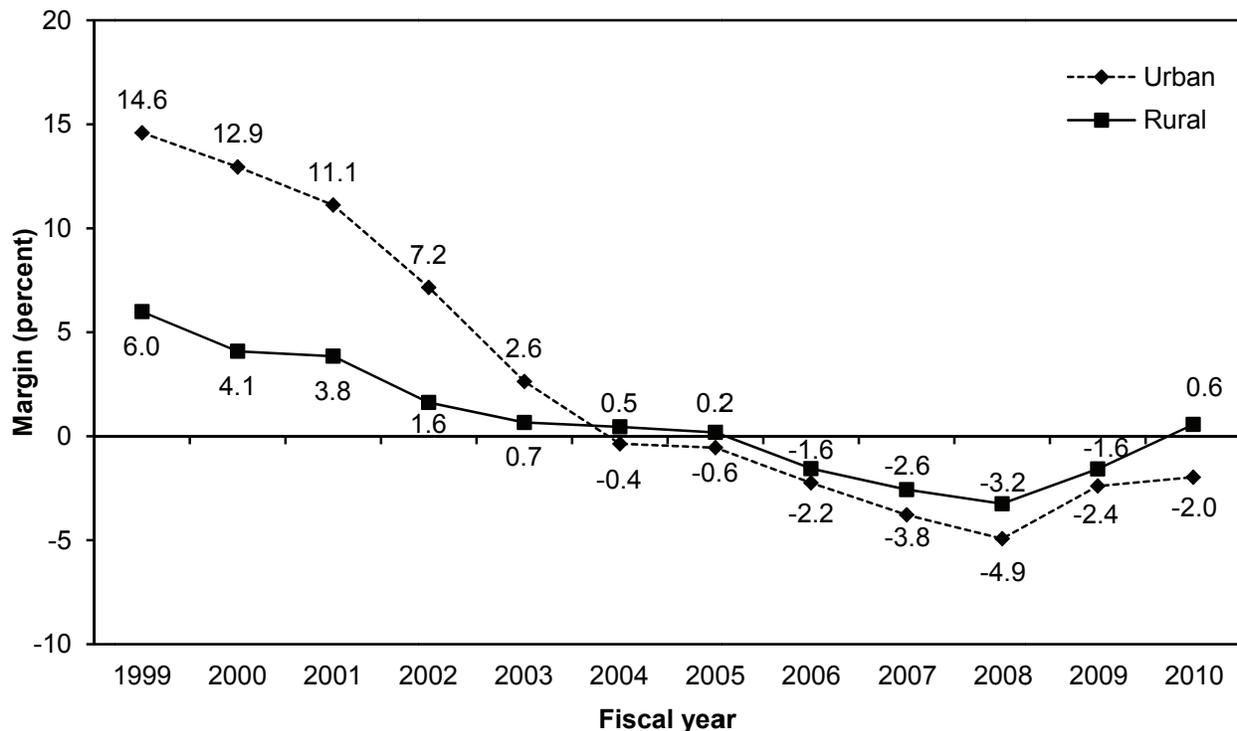


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Medicare’s acute inpatient margin reflects payments and costs for services covered by Medicare’s inpatient hospital prospective payment system. The inpatient margin may be influenced by how hospitals allocate overhead costs across service lines. Only by combining data for all major services can we estimate Medicare costs without the potential influence of how overhead costs are allocated (see Chart 6-15).
- Following the implementation of the Balanced Budget Act of 1997, inpatient margins declined over the next 10 years as costs rose faster than the 3 percent average annual increase in Medicare payments. In 2010, the margin was –1.7 percent, up slightly from 2009.
- Medicare inpatient margins vary widely. In 2010, one-quarter of hospitals had Medicare inpatient margins that were 8.4 percent or higher, and another quarter had inpatient margins that were –16.3 percent or lower. Forty-three percent of hospitals had positive inpatient Medicare margins in 2010.

Chart 6-14. Medicare acute inpatient PPS margin, by urban and rural location, 1999–2010

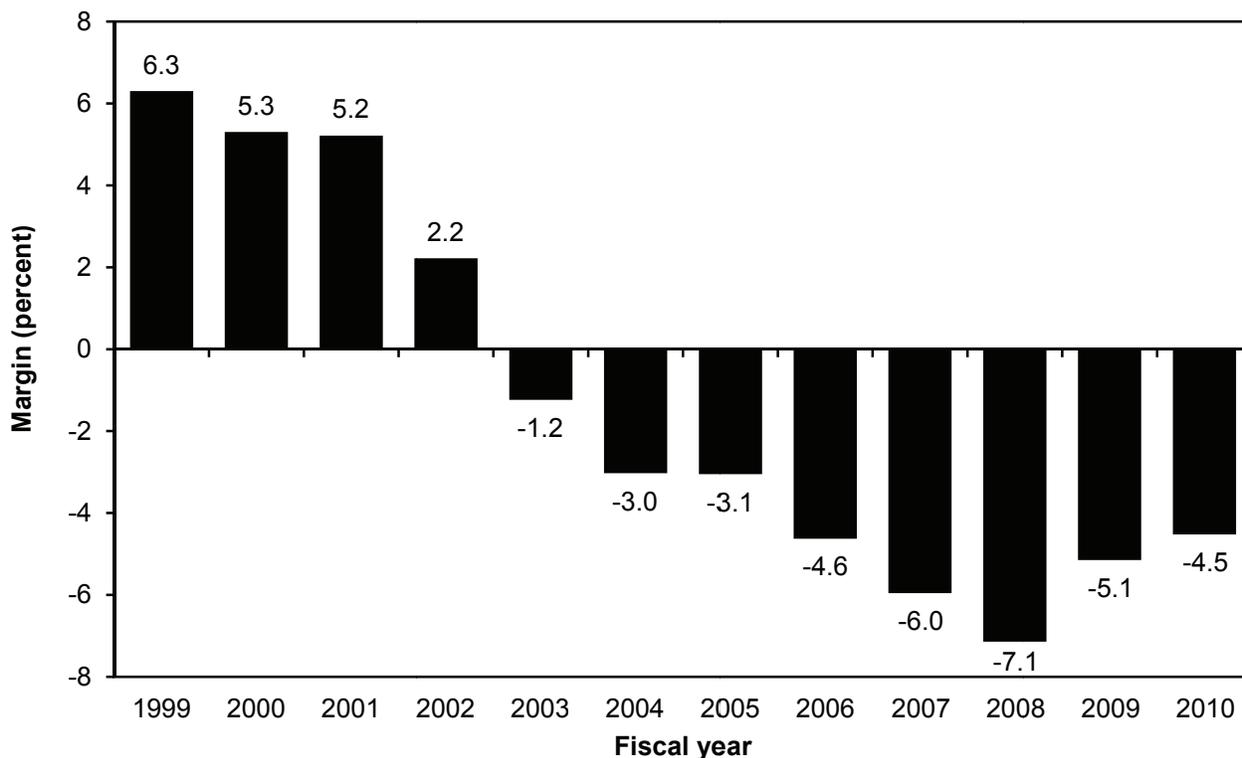


Note: PPS (prospective payment system). A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Medicare acute inpatient margin includes services covered by the acute care inpatient PPS.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Urban hospitals historically had higher Medicare inpatient margins than rural hospitals, but this difference began to narrow in 2002, and today urban hospitals' margins are lower than those of rural hospitals. In recent years, Medicare inpatient margins of rural hospitals have been higher than those of urban hospitals.
- The gap between urban and rural hospitals' Medicare inpatient margins was wide between 1999 and 2001. One factor in this gap was that urban hospitals had greater success in controlling cost growth, at least partly in response to pressures from managed care. From 2001 to 2004, the difference narrowed, and from 2004 to 2010, rural hospitals' inpatient margins were slightly higher than those for urban hospitals. In 2010, the margins of rural and urban hospitals were 0.6 percent and –2.0 percent, respectively. The narrowing between these two groups of hospitals as of 2001 was the result of payment policies targeted at raising rural hospital payments, as well as growth in the number of critical access hospitals, which removed many rural hospitals with low margins from the prospective payment system.

Chart 6-15. Overall Medicare margin, 1999–2010

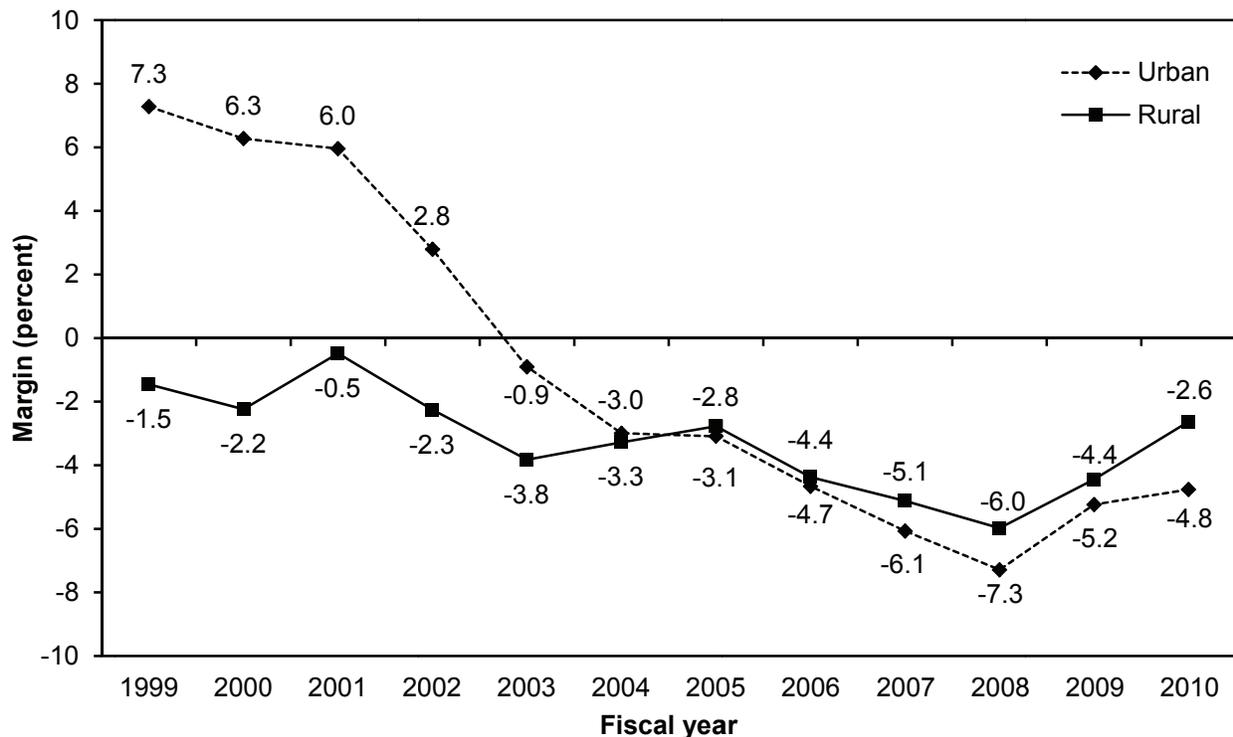


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as graduate medical education and bad debts.

Source: MedPAC analysis of Medicare cost report data from CMS.

- The overall Medicare margin incorporates payments and costs for acute inpatient, outpatient, skilled nursing, home health care, and inpatient psychiatric and rehabilitative services, as well as direct graduate medical education and bad debts. The overall margin follows a trend similar to that for the Medicare inpatient margin.
- The overall Medicare margin in 1999 was 6.3 percent. In fiscal year 2010, it was –4.5 percent.
- In 2010, one-quarter of hospitals had overall Medicare margins of 4.6 percent or higher, and another quarter had margins of –15.8 percent or lower. Between 2000 and 2008, the difference in performance between the top and bottom quartile widened from 17 percentage points to 22 percentage points, but narrowed to 20 percentage points in 2010. About 37 percent of hospitals had positive overall Medicare margins in 2010.

Chart 6-16. Overall Medicare margin, by urban and rural location, 1999–2010

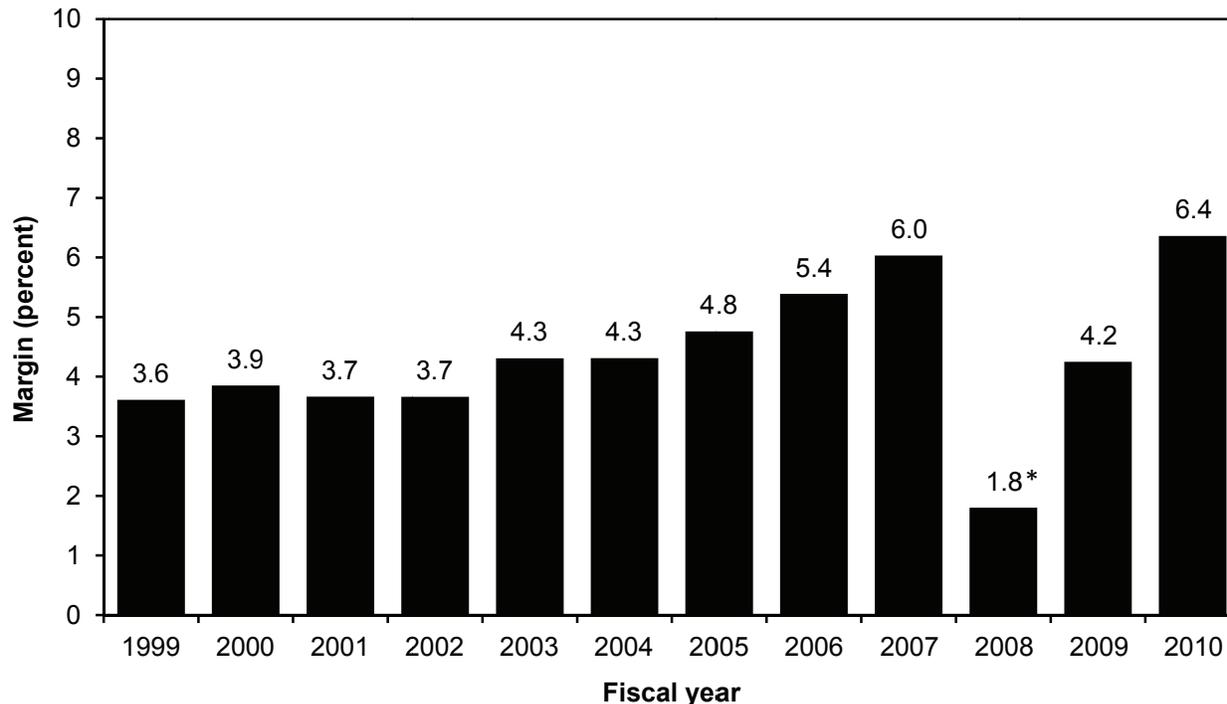


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and exclude critical access hospitals. Overall Medicare margins cover the costs and payments of acute hospital inpatient, outpatient, inpatient psychiatric and rehabilitation unit, skilled nursing facility, and home health services, as well as direct graduate medical education and bad debts.

Source: MedPAC analysis of Medicare cost report data from CMS.

- As with inpatient margins, overall Medicare margins historically were higher for urban hospitals than for rural hospitals, but since 2005 overall Medicare margins for rural hospitals have gradually begun to slightly exceed those for urban hospitals.
- The difference in overall Medicare margins between urban and rural hospitals grew between 1997 and 2000, but has since narrowed. In 1997, the overall margin for urban hospitals was 11.6 percent, compared with 6.1 percent for rural hospitals. In 2010, the overall Medicare margin for urban hospitals was -4.8 percent, compared with -2.6 percent for rural hospitals. Policy changes made in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 targeted to rural hospitals helped to improve the relative financial position of rural hospitals. Further legislation to assist rural hospitals was implemented after 2008.

Chart 6-17. Hospital total all-payer margin, 1999–2010



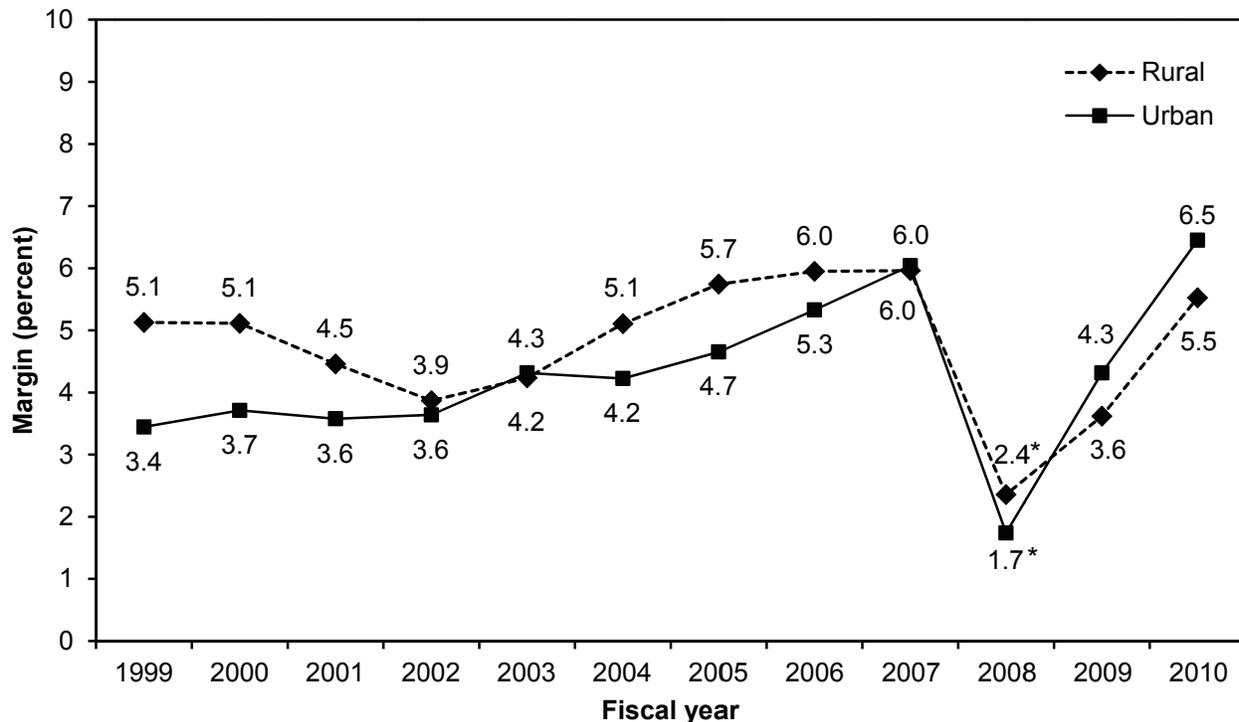
Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

*The significant drop in total margin includes investment losses stemming from the decline of the U.S. stock market in 2008.

Source: MedPAC analysis of Medicare cost report data from CMS.

- The total hospital margin for all payers—Medicare, Medicaid, other government, and private payers—reflects the relationship of all hospital revenues to all hospital costs, including inpatient, outpatient, post-acute, and nonpatient services. The total margin also includes nonpatient revenue, such as investment revenues. Other types of margins we track, Medicare inpatient margin and overall Medicare margin, are operating margins that do not include investment revenue.
- From 1999 to 2007, total margins increased to the highest level in a decade. In 2008, the total margin declined to 1.8 percent, its lowest level since the inpatient prospective payment system was implemented. The 2008 decline of the U.S. stock market resulted in significant investment losses for hospitals, which resulted in a corresponding decline in total margin. In 2010, total margin increased again to 6.4 percent, the highest it has been in over a decade.
- In 2010, 75 percent of hospitals had positive total margins. The total margin varied much less than the Medicare inpatient or overall Medicare margin. In 2010, one-quarter of prospective payment system hospitals had total margins that were 9.0 percent or higher, while another one-quarter had margins that were at or below zero, a spread of roughly 9 percentage points compared with a 25 percentage point spread for Medicare inpatient margins and a 20 percentage point spread for overall Medicare margins.

Chart 6-18. Hospital total all-payer margin, by urban and rural location, 1999–2010

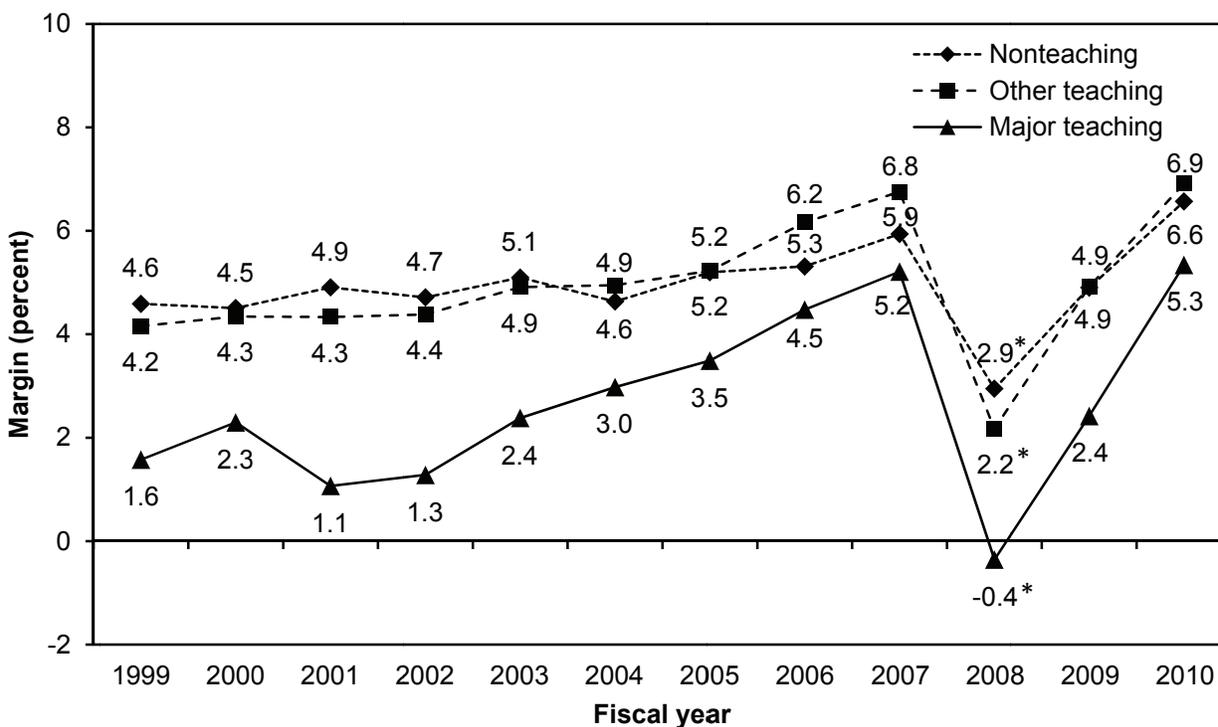


Note: A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue such as investment revenues. Analysis excludes critical access hospitals.
*Significant drop in total margin includes investment losses resulting from the U.S. stock market decline of 2008.

Source: MedPAC analysis of Medicare cost report data from CMS.

- In 2009 and 2010, urban hospitals had higher total (all-payer) margins than rural hospitals. In 2010, total margins were 6.5 percent for urban hospitals and 5.5 percent for rural hospitals. The growth in margins in 2009 and 2010 reflects low cost growth and increasing private payer reimbursement rates.
- In 2008, both rural and urban hospitals experienced their lowest level of total (all-payer) margins in the last 15 years. Hospitals' total margin includes all patient care services funded by all payers, plus non-patient revenue, such as investment revenues. The 2008 decline of the U.S. stock market resulted in significant investment losses for hospitals, which in turn resulted in a corresponding decline in total margins. Other types of margins we track, Medicare inpatient margin and overall Medicare margin, are operating margins that do not include investment revenue.

Chart 6-19. Hospital total all-payer margin, by teaching status, 1999–2010



Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of greater than 0 and less than 0.25. A margin is calculated as revenue minus costs, divided by revenue. Total margin includes all patient care services funded by all payers, plus nonpatient revenue. Analysis excludes critical access hospitals.

*Significant drop in total margin includes investment losses resulting from the U.S. stock market decline of 2008.

Source: MedPAC analysis of Medicare cost report data from CMS.

- The pattern of total margins by teaching status is the opposite of the pattern for the Medicare inpatient and overall Medicare margins. The total margins for major teaching hospitals have consistently been lower than those for other teaching and nonteaching hospitals. In 2010, the total margin for major teaching hospitals stood at 5.3 percent compared with other teaching hospitals and nonteaching hospitals at 6.9 percent and 6.6 percent, respectively.
- In 2010, major teaching hospitals' total (all-payer) margins reached their highest point in more than two decades, at 5.3 percent. Their previous high came in 2007, when their total (all-payer) margins reached 5.2 percent. However, in 2008, this trend was interrupted by a steep decline in their investment revenues.

Chart 6-20. Medicare margins by teaching and disproportionate share status, 2010

Hospital group	Share of hospitals	Share of Medicare inpatient payments	Medicare inpatient margin	Overall Medicare margin
All hospitals	100%	100%	-1.7%	-4.5%
Major teaching	8	23	7.5	-0.1
Other teaching	23	36	-2.3	-4.4
Nonteaching	69	41	-6.4	-7.0
Both IME and DSH	27	54	2.7	-1.8
IME only	4	6	-9.8	-10.9
DSH only	53	32	-3.2	-4.9
Neither IME nor DSH	16	9	-17.5	-14.3

Note: IME (indirect medical education), DSH (disproportionate share). Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of 2010 Medicare cost report data from CMS.

- Major teaching hospitals had the highest Medicare inpatient and overall Medicare margins in 2010. Their better financial performance was largely due to the additional payments they received from the IME and DSH adjustments.
- Hospitals that received neither IME nor DSH payments had the lowest Medicare margins. In 2010, the Medicare inpatient margins of these hospitals were about 25 percentage points below those of major teaching hospitals, and overall Medicare margins were nearly 15 percentage points lower.

Chart 6-21. Financial pressure leads to lower costs

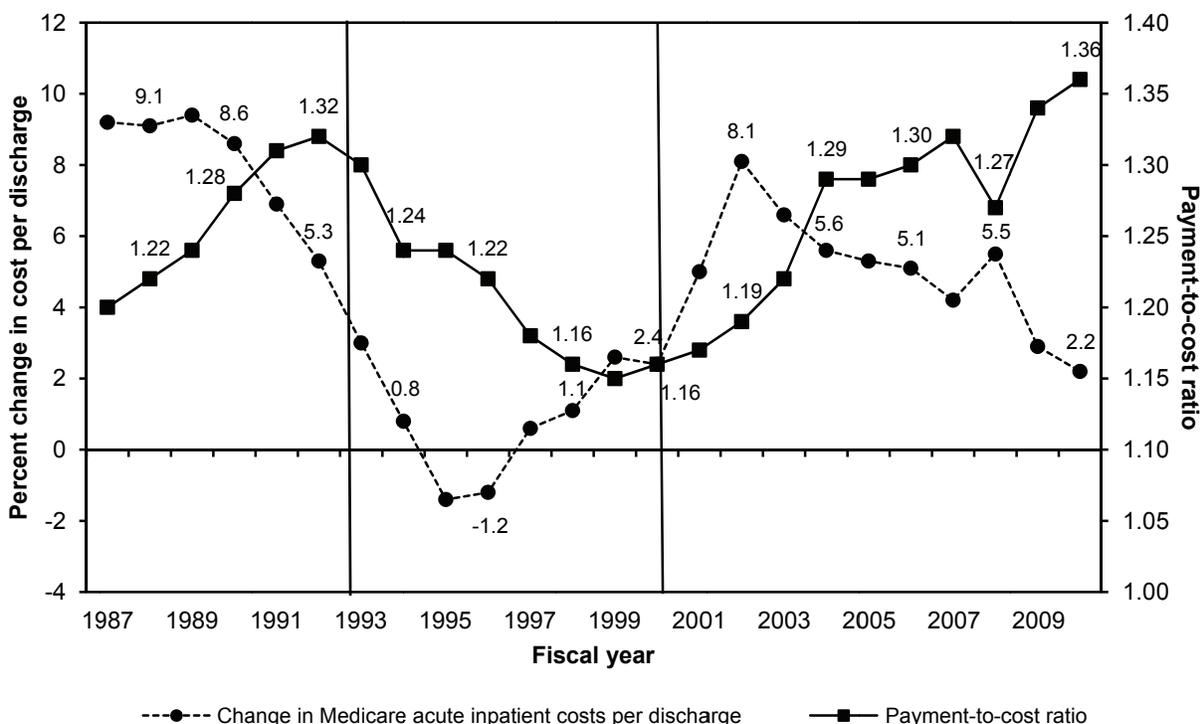
	Level of financial pressure, 2005–2009		
	High pressure (non-Medicare margin \leq 1%)	Medium pressure	Low pressure (non-Medicare margin $>$ 5%)
Number of hospitals	742	438	1,712
Financial characteristics, 2010 (medians)			
Non-Medicare margin (private, Medicaid, uninsured)	-3.6%	3.3%	12.4%
Standardized cost per discharge (as a share of the national median)			
For-profit and nonprofit	90	97	105
Nonprofit hospital	89	97	106
For-profit hospital	92	96	101
Annual growth in cost per discharge, 2007–2010	3.3%	3.3%	3.7%
Overall 2010 Medicare margin (medians)	5.5%	-1.6%	-9.2%
Patient characteristics (medians)			
Total hospital discharges in 2010	4,500	7,728	7,475
Medicare share of inpatient days	44%	41%	42%
Medicaid share of inpatient days	12	12	10
Medicare case mix index	1.31	1.42	1.48

Note: Standardized costs are adjusted for hospital case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on hospital costs. The sample includes all hospitals that had complete cost reports on file with CMS by August 2011.

Source: MedPAC analysis of Medicare cost report and claims files from CMS.

- Higher financial pressure tends to lead to lower cost growth and lower costs per discharge. Hospitals with lower volume, lower case mix, and higher Medicaid charges are more likely to be under financial pressure.

Chart 6-22. Change in Medicare hospital inpatient costs per discharge and private payer payment-to-cost ratio, 1987–2010

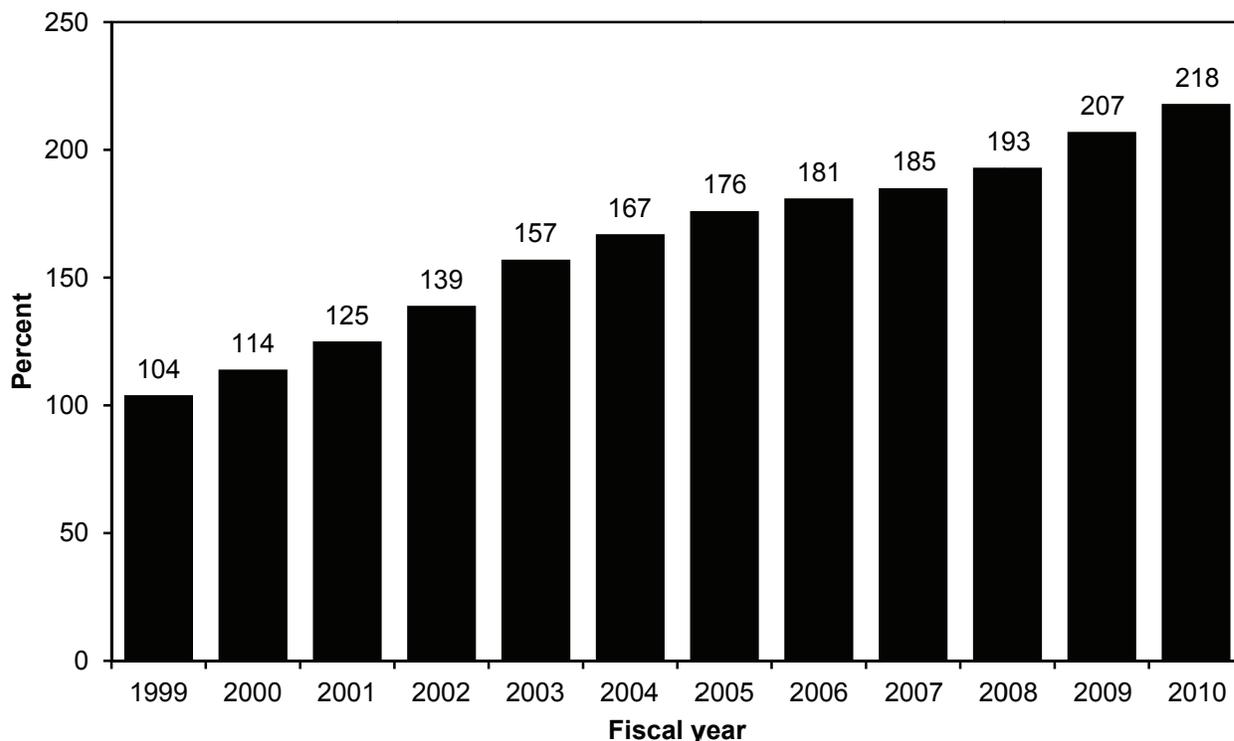


Note: Data are for community hospitals and cover all hospital services. Imputed values were used for missing data (about one-third of observations). Data for 2006–2010 exclude Medicare and Medicaid managed care patients from the private payment-to-cost ratio. The private payment-to-cost ratio includes self-pay patients. If we excluded self-pay patients, the payment-to-cost ratio for 2010 would be higher, at approximately 1.42.

Source: MedPAC analysis of Medicare Cost Report files from CMS and CMS's rules for the acute inpatient prospective payment system and American Hospital Association Annual Survey of Hospitals.

- The pattern of growth in Medicare costs per discharge makes it clear that hospitals have responded strongly to the incentives posed by the rise and fall of financial pressure from private payers over three distinct periods between 1987 and 2010.
- During the first period, 1987–1992, private payers' payments rose much faster than the cost of treating their patients (seen in the chart as a steep increase in the payment-to-cost ratio). This result suggests an almost complete lack of pressure from private payers. Medicare costs per discharge rose 8.3 percent per year during these years, more than 3 percentage points a year above the increase in Medicare's market basket index.
- As HMOs and other private insurers exerted more pressure during the second period, 1993–1999, the private payer payment-to-cost ratio dropped substantially. The rate of cost growth plummeted to an average of only 0.8 percent per year, which was more than 2 percentage points below the average increase in the market basket.
- As pressure from private payers waned after 1999, the private payer payment-to-cost ratio rose sharply, and hospital cost growth exceeded growth in the market basket by 2 percentage points a year. In 2005–2007, the growth in private payer profit margins slowed, and in 2007, cost growth more closely matched the market basket.
- In 2010, the private payer payment-to-cost ratio increased as cost growth was lower than payment rate increases. The slow cost growth in 2010 may reflect financial pressure stemming from 2008 investment portfolio losses and economic uncertainty (see Chart 6-17).

Chart 6-23. Markup of charges over costs for Medicare services, 1999–2010

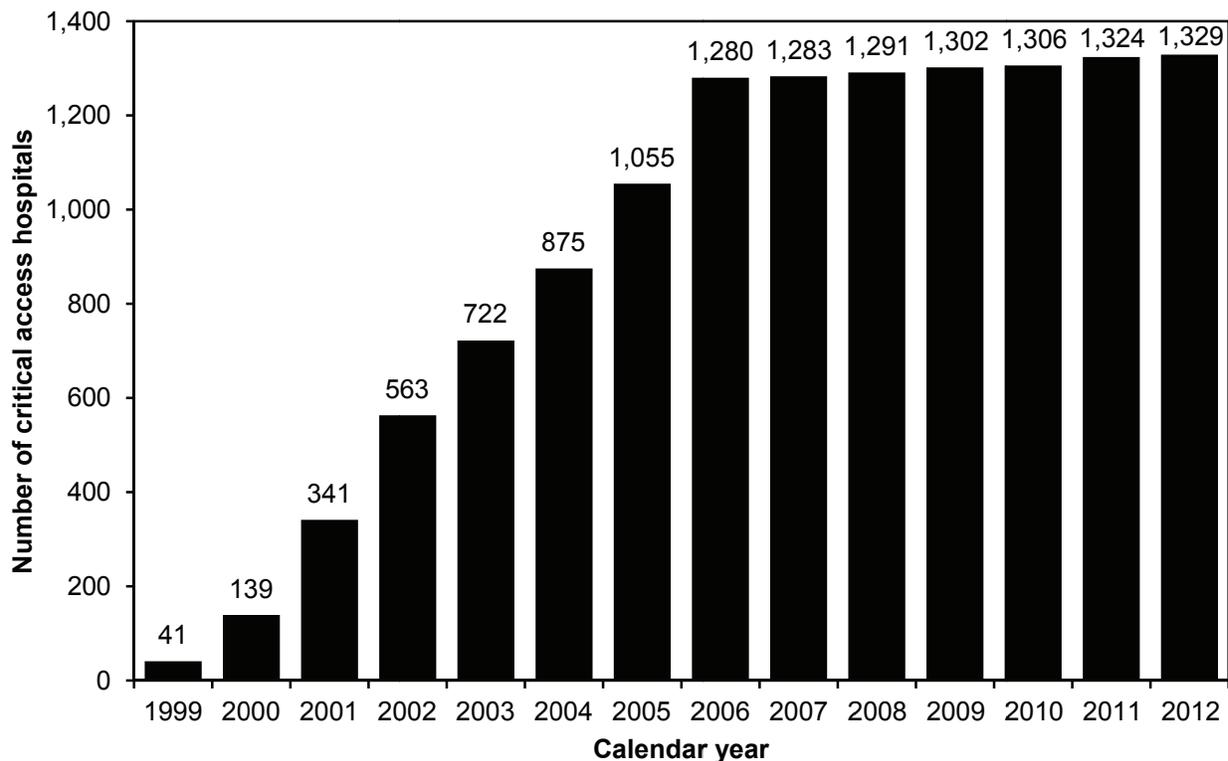


Note: Analysis includes all community hospitals.

Source: American Hospital Association Annual Survey of Hospitals.

- The markup of charges over costs rose from about 104 percent in 1999 to 218 percent in 2010. Charges now exceed costs by more than a factor of 3.
- Rapid growth in charges may have little impact on hospital financial performance, because few patients pay full charges. However, charge growth may significantly affect uninsured patients, who may pay full charges. More rapid growth in charges (relative to growth in costs) may reflect hospitals' attempts to maximize revenue from private payers (who often structure their payments as a discount off charges). The unusually large increases in charges in 2002 and 2003 may have resulted from some hospitals manipulating Medicare outlier payments. Toward the end of fiscal year 2003, Medicare revised its outlier policy in an attempt to curb hospitals' opportunity to increase their outlier payments through excessive increases in charges.
- The markup of charges over costs is generally higher for urban hospitals (236 percent in 2010) than for rural hospitals (179 percent in 2010).

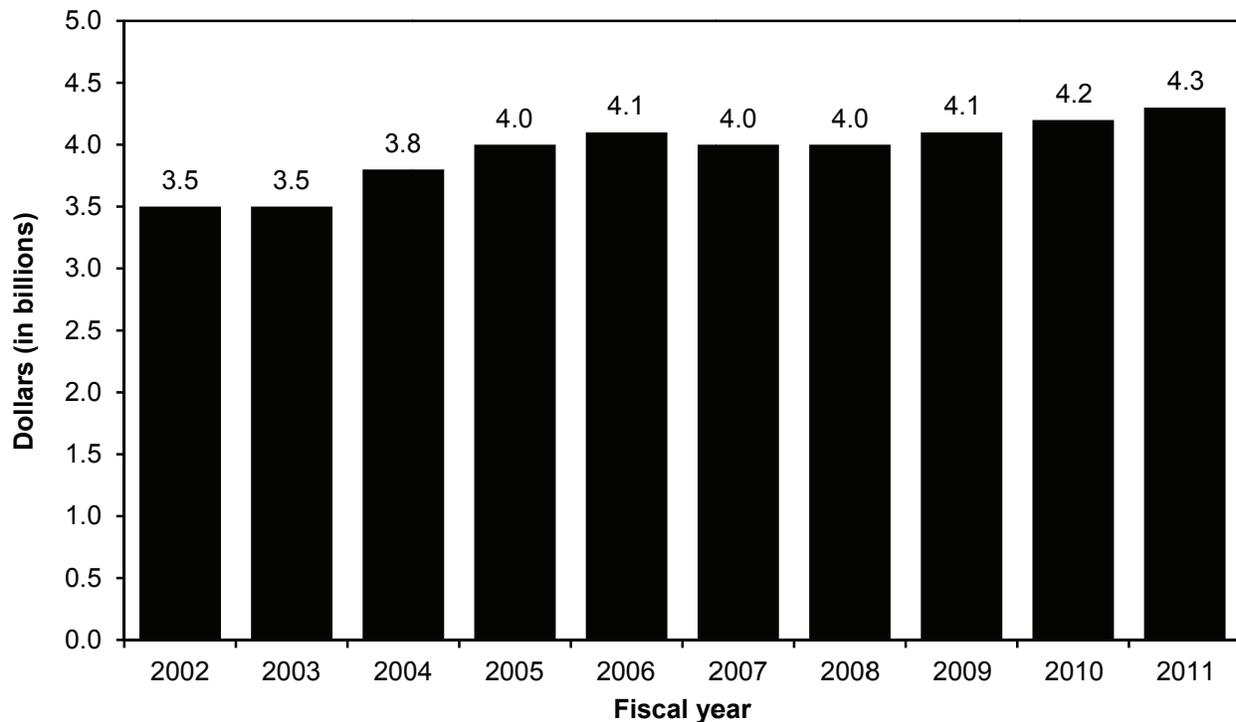
Chart 6-24. Number of critical access hospitals, 1999–2012



Source: The Medicare Rural Hospital Flexibility Program and CMS.

- The number of critical access hospitals (CAHs) grew rapidly from 1999 to 2006, but has since leveled off at approximately 1,300 facilities.
- The increase in CAHs is in part due to a series of legislative changes that made conversion to CAH status easier and expanded the services that qualify for cost-based reimbursement. Currently, CAHs are paid their Medicare costs plus 1 percent for inpatient services, outpatient services (including laboratory and therapy services), and post-acute services in swing beds.
- Before 2006, a hospital could convert to CAH status if it was (1) 35 miles by primary road or 15 miles by secondary road from the nearest hospital, or (2) the state waived the distance requirement by declaring the hospital a “necessary provider.” Starting in 2006, states could no longer waive the distance requirement. While most existing CAHs fail the distance test, they are grandfathered into the program. Among small rural hospitals that have not converted, most would not meet the distance requirement. Therefore, we expect the number of CAHs to remain fairly constant.

Chart 6-25. Medicare payments to inpatient psychiatric facilities, 2002–2011



Source: CMS, Office of the Actuary.

- The inpatient psychiatric facility prospective payment system started January 1, 2005.
- Medicare program spending for beneficiaries' care in inpatient psychiatric facilities grew an estimated 2.3 percent per year between 2002 and 2011.
- Inpatient psychiatric care furnished in scatter beds in acute care hospitals and paid under the acute care inpatient prospective payment system is not included in this chart.

Chart 6-26. Number of inpatient psychiatric facility cases has fallen under the PPS, 2002–2009

	TEFRA		PPS			Average annual change 2002–2004	Average annual change 2004–2009
	2002	2004	2006	2008	2009		
Cases	464,780	483,271	474,417	442,759	431,276	2.0%	–2.3%
Cases per 1,000 FFS beneficiaries	13.3	13.2	13.1	12.5	12.3	–0.2	–1.5
Spending per FFS beneficiary	\$90.6	\$96.8	\$104.7	\$109.5	\$111.3	3.4	2.8
Payment per case	\$6,822	\$7,328	\$7,989	\$8,742	\$9,080	3.6	4.4
Payment per day	\$570	\$627	\$677	\$728	\$763	4.9	4.0
Length of stay (in days)	13.0	12.7	13.0	13.1	13.1	–1.2	0.6

Note: PPS (prospective payment system), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), fee-for-service (FFS). Numbers of cases and patients reflect Medicare FFS utilization of services furnished in inpatient psychiatric facilities (IPFs). Scatter bed cases and spending are excluded, as are cases and spending for beneficiaries enrolled in Medicare Advantage plans.

Source: MedPAC analysis of MedPAR data from CMS.

- Since a prospective payment system for IPFs was implemented in January 2005, the number of cases in IPFs has fallen, on average, about 2.3 percent per year. Controlling for the number of beneficiaries enrolled in FFS Medicare, IPF cases fell 1.5 percent per year between 2004 and 2009.

Chart 6-27. Inpatient psychiatric facilities, 2003–2009

Type of IPF	TEFRA		PPS					Annual change 2003–2004	Average annual change 2004–2009
	2003	2004	2005	2006	2007	2008	2009		
All	1,703	1,657	1,623	1,590	1,584	1,564	1,536	–2.7%	–1.5%
Urban	1,298	1,277	1,283	1,267	1,262	1,251	1,210	–1.6	–1.1
Rural	405	378	340	323	322	313	326	–6.7	–2.9
Freestanding	353	352	366	396	412	420	426	–0.3	3.9
Hospital-based units	1,350	1,305	1,257	1,194	1,172	1,144	1,110	–3.3	–3.2
Nonprofit	974	949	910	878	849	831	802	–2.6	–3.3
For profit	349	327	344	343	359	352	368	–6.3	2.4
Government	380	381	369	369	376	381	366	0.3	–0.8

Note: IPF (inpatient psychiatric facility), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Numbers are facilities that submitted valid Medicare cost reports in the given fiscal year.

Source: MedPAC analysis of Medicare cost report files from CMS.

- Between 2003 and 2004, the number of freestanding IPFs remained fairly steady. Beginning in 2005, when the IPF PPS began to be implemented, the number of freestanding IPFs grew an average of 3.9 percent per year. By comparison, the number of distinct-part psychiatric units in acute care hospitals fell by 3.3 percent between 2003 and 2004, a decline that continued after the PPS was implemented. Much of the decline in psychiatric units occurred among nonprofit and rural facilities.
- The drop in the number of psychiatric units likely has several causes. Psychiatric units may not be as profitable as they once were, particularly when compared with other acute care hospital services. Other factors, such as the availability of psychiatrists to provide on-call services in hospital emergency departments, may also affect acute care hospitals' decisions to close their psychiatric units.

Chart 6-28. One diagnosis accounted for almost three-quarters of IPF cases in 2009

MS-DRG	Diagnoses	Percentage
885	Psychosis	73.1%
057	Degenerative nervous system disorders without MCC	7.5
884	Organic disturbances & mental retardation	5.8
897	Alcohol/drug abuse or dependency, no rehabilitation, without MCC	4.2
881	Depressive neurosis	3.3
882	Neurosis except depressive	1.1
895	Alcohol/drug abuse or dependency with rehabilitation, without MCC	0.9
056	Degenerative nervous system disorders with MCC	0.8
880	Acute adjustment reaction & psychosocial dysfunction	0.7
886	Behavioral and developmental disorders	0.5
883	Disorders of personality & impulse control	0.5
894	Alcohol/drug use—left AMA	0.2
896	Alcohol/drug abuse or dependency without rehabilitation, with MCC	0.2
876	OR procedure with principal diagnosis of mental illness	0.1
887	Other mental disorders	0.1
081	Nontraumatic stupor & coma without MCC	0.1
080	Nontraumatic stupor & coma with MCC	0.0
	Nonpsychiatric MS-DRGs	0.9
	Total	100.0

Note: IPF (inpatient psychiatric facility), MS-DRG (Medicare severity–diagnosis related group), MCC (major comorbidity or complication), AMA (against medical advice), OR (operating room).

Source: MedPAC analysis of MedPAR data from CMS.

- Medicare patients in IPFs are generally assigned to 1 of 17 psychiatric Medicare severity–diagnosis related groups. In 2009, the most frequently occurring IPF diagnosis—accounting for 73 percent of IPF discharges—was psychoses. The next most common discharge, accounting for almost 8 percent of IPF cases, was degenerative nervous system disorders.

Chart 6-29. IPF discharges by beneficiary characteristics, 2009

Characteristic	Share of total IPF discharges
Current eligibility status*	
Aged	34.9%
Disabled	65.0
ESRD only	0.1
Age (years)	
<45	28.3
45–64	36.4
65–79	21.1
80+	14.6
Race	
White	77.1
African American	17.3
Hispanic	2.7
Other	2.9

Note: IPF (inpatient psychiatric facility), ESRD (end-stage renal disease). Numbers may not sum to totals due to rounding.
 *Some aged beneficiaries are also disabled.

Source: MedPAC analysis of MedPAR data from CMS.

- Most Medicare beneficiaries treated in IPFs qualify for Medicare because of a disability. As a result, IPF patients tend to be younger and poorer than the typical fee-for-service beneficiary.
- Diagnosis patterns differed by age and race. Among the top Medicare severity–diagnosis related groups in 2009, degenerative nervous system disorders, such as dementia, were much more common in older patients, while psychoses were more common in younger patients.
- A majority of beneficiaries admitted to IPFs are dually eligible for Medicare and Medicaid. In 2009, 59 percent of Medicare beneficiaries with at least one IPF discharge were dually eligible for at least one month of the year.

Web links. Acute inpatient services

Short-term hospitals

- Chapter 3 of the MedPAC March 2012 Report to the Congress provides additional detailed information on hospital margins.

http://www.medpac.gov/chapters/Mar12_Ch03.pdf

- MedPAC provides basic information about the acute inpatient prospective payment system in its Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_hospital.pdf

- CMS provides information on the hospital market basket.

<http://www.cms.gov/MedicareProgramRatesStats/downloads/info.pdf>

- CMS published the acute inpatient prospective payment system rule for fiscal year 2011 in the *Federal Register*.

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2011-IPPS-Final-Rule-Home-Page-Items/CMS1237907.html>

Inpatient psychiatric facilities

- Chapter 6 of the MedPAC June 2010 Report to the Congress provides information on inpatient psychiatric facilities.

http://www.medpac.gov/chapters/Jun10_Ch06.pdf

- MedPAC provides basic information about the inpatient psychiatric facility prospective payment system in its Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_psych.pdf

- CMS provides information on the inpatient psychiatric facility prospective payment system.

<http://www.cms.gov/InpatientPsychFacilPPS/>

- CMS describes updates to the inpatient psychiatric facility prospective payment system for the rate year beginning July 1, 2011, in the January 27, 2011, *Federal Register*.

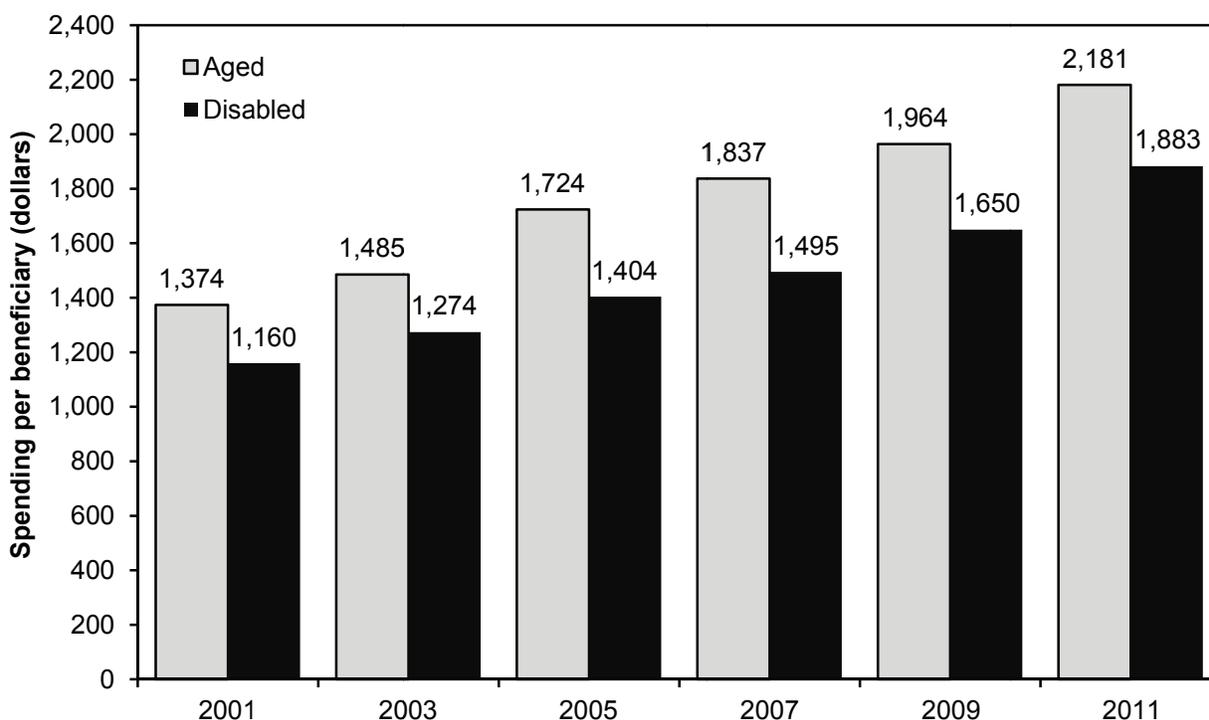
<http://edocket.access.gpo.gov/2011/pdf/2011-1507.pdf>

SECTION

7

Ambulatory care
Physicians
Hospital outpatient services
Ambulatory surgical centers
Imaging services

Chart 7-1. Medicare spending per FFS beneficiary on physician fee-schedule services, 2001–2011

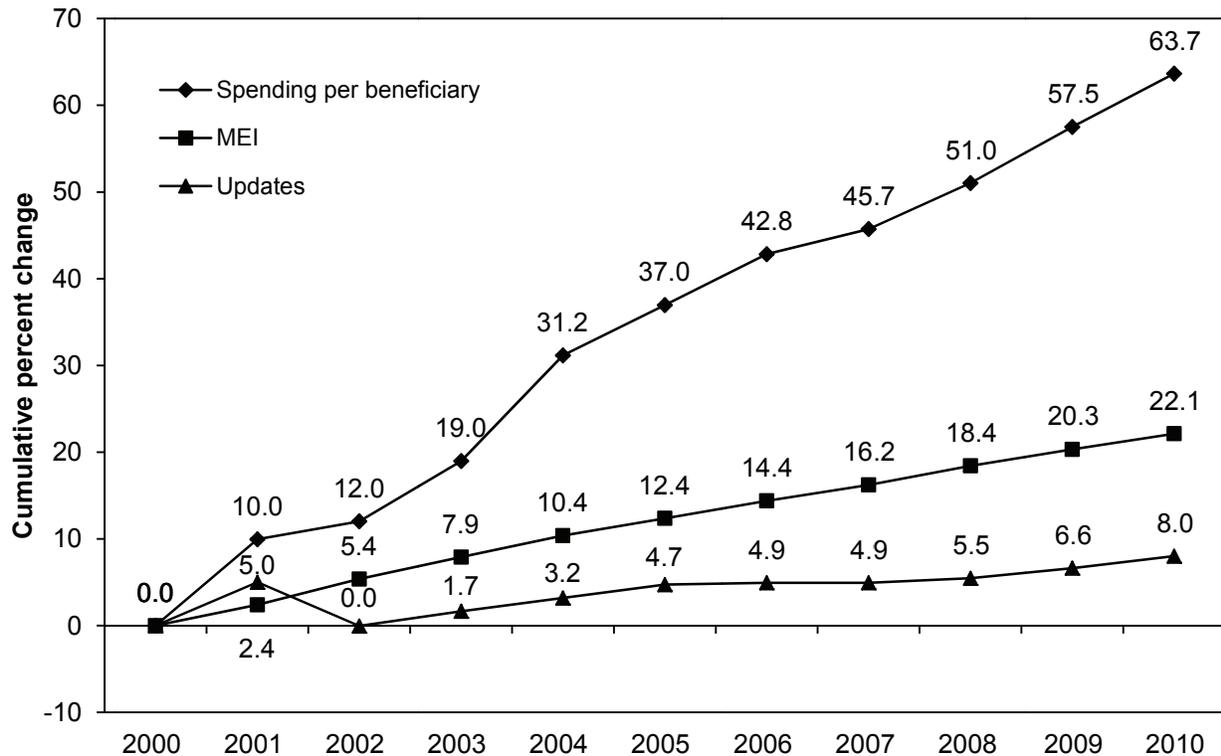


Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. The category "disabled" excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries age 65 or over are included in the aged category.

Source: 2011 and 2012 annual reports of the Boards of Trustees of the Medicare trust funds.

- Physicians and other health professionals perform a broad range of services in the Medicare physician fee schedule, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In addition to physicians, these services may be provided by other health professionals (e.g., nurse practitioners, chiropractors, and physical therapists).
- FFS spending per beneficiary for physician fee-schedule services has increased annually. From 2001 to 2011, Medicare spending per FFS beneficiary on these services grew 58 percent.
- Growth in spending on physician fee-schedule services is one of several contributions to Part B premium increases over this time period.
- Per capita spending for disabled beneficiaries (under age 65) is lower than per capita spending for aged beneficiaries. In 2011, for example, per capita spending for disabled beneficiaries was \$1,883 compared with \$2,181 for aged beneficiaries.

Chart 7-2. Volume growth has raised physician spending more than input prices and payment updates, 2000–2010

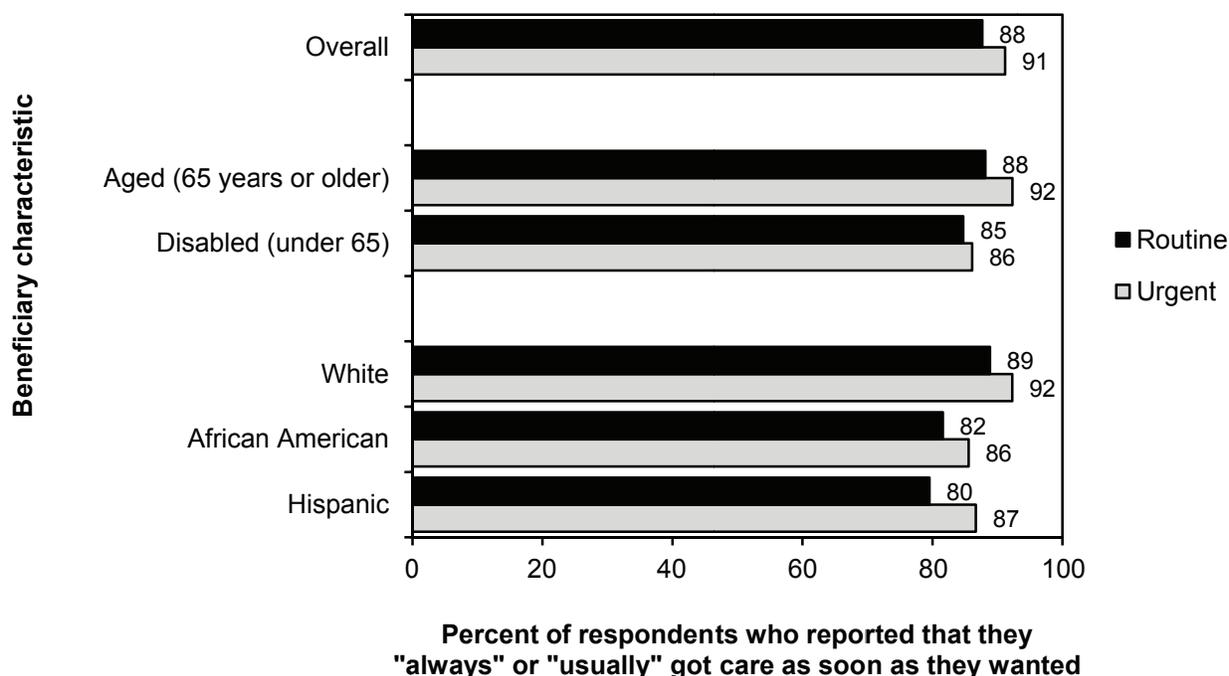


Note: MEI (Medicare Economic Index).

Source: 2011 annual report of the Boards of Trustees of the Medicare trust funds, IHS Global Insight data through fourth quarter of 2010, and data from the Office of the Actuary.

- From 2000 to 2010, Medicare spending for physician services—per beneficiary—increased by 64 percent.
- This spending grew much more rapidly over the period than both the payment rate updates and the MEI. Physician fee schedule payment updates totaled 8 percent, and the MEI increased 22 percent.
- Growth in the volume of services contributed much more to the rapid increase in Medicare spending than payment rate updates. Both factors—updates and volume growth—combine to increase physician revenues.

Chart 7-3. Most beneficiaries report that they can always or usually get timely care, 2011



Note: In the survey, routine care refers to appointments in doctors' offices or clinics that are not for care needed "right away." Urgent care refers to care needed "right away" for an illness, injury, or condition. Nonapplicable respondents (e.g., those who did not seek routine or urgent care in the last six months) were excluded.

Source: MedPAC analysis of CAHPS® (Consumer Assessment of Healthcare Providers and Systems®) for fee-for-service Medicare, 2011.

- Overall, 88 percent of Medicare beneficiaries who reported making an appointment for routine care at a doctor's office or clinic said that they always or usually got care as soon as they wanted. For beneficiaries who reported needing urgent care in a clinic, emergency room, or doctor's office, 91 percent reported that they always or usually got care as soon as they wanted.
- Compared with beneficiaries age 65 or older, those under age 65 and eligible for Medicare on the basis of disability were less likely to report that they always or usually got routine or urgent care as soon as they wanted.
- Smaller percentages of African American and Hispanic beneficiaries reported that they always or usually got care as soon as they wanted, compared with White beneficiaries.

Chart 7-4. Medicare beneficiaries report better ability to get timely appointments with physicians, compared with privately insured individuals, 2008–2011

Survey question	Medicare (age 65 or older)				Private insurance (age 50–64)			
	2008	2009	2010	2011	2008	2009	2010	2011
Unwanted delay in getting an appointment: Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”								
For routine care								
Never	76% ^a	77% ^a	75% ^a	74% ^a	69% ^a	71% ^a	72% ^a	71% ^a
Sometimes	17 ^a	17 ^a	17 ^a	18 ^a	24 ^a	22 ^a	21 ^a	21 ^a
Usually	3 ^a	2 ^{ab}	3 ^a	3	5 ^a	3 ^a	4 ^a	4
Always	2	2	2	2 ^a	2	3	3	3 ^a
For illness or injury								
Never	84 ^a	85 ^{ab}	83 ^a	82	79 ^a	79 ^a	80 ^a	79
Sometimes	12 ^a	11 ^{ab}	13 ^a	14 ^a	16 ^a	17 ^a	15 ^a	17 ^a
Usually	1	2	2	2	2	2	2	2
Always	1 ^a	1	1 ^a	1	2 ^a	2	2 ^a	1

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 3,000 in 2008 and 4,000 in years 2009, 2010, and 2011. Sample sizes for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.

^b Statistically significantly different (at a 95 percent confidence level) from 2011 within the same insurance coverage category.

Source: MedPAC-sponsored telephone surveys, conducted in 2008, 2009, 2010, and 2011.

- Most Medicare beneficiaries have one or more doctor appointments in a given year. Therefore, one access indicator we examine is their ability to schedule timely appointments.
- Medicare beneficiaries report better access to physicians for appointments compared with privately insured individuals age 50 to 64. For example, in 2011, 74 percent of Medicare beneficiaries and 71 percent of privately insured individuals reported “never” having to wait longer than they wanted to get an appointment for routine care.
- Medicare beneficiaries also report more timely appointments for injury and illness compared with their privately insured counterparts.
- As expected, appointment scheduling for illness and injury is better than for routine care appointments for both Medicare beneficiaries and privately insured individuals.

Chart 7-5. Medicare and privately insured patients who are looking for a new physician report more difficulty finding one in primary care, 2008–2011

Survey question	Medicare (age 65 or older)				Private insurance (age 50–64)			
	2008	2009	2010	2011	2008	2009	2010	2011
Looking for a new physician: “In the past 12 months, have you tried to get a new ...?” (Percent answer “Yes”)								
Primary care physician	6%	6%	7%	6%	7%	8%	7%	7%
Specialist	14 ^a	14 ^a	13 ^a	14 ^a	19 ^a	19 ^a	15 ^a	16 ^a
Getting a new physician: Among those who tried to get an appointment with a new physician, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it...”								
Primary care physician								
No problem	71	78 ^b	79 ^{ab}	65	72	71	69 ^a	68
Small problem	10	10	8	12	13	8 ^b	12	16
Big problem	18	12 ^{ab}	12 ^b	23 ^a	13	21 ^a	19	14 ^a
Specialist								
No problem	88	88	87 ^a	84	83	84	82 ^a	86
Small problem	7	7	6 ^a	8	9	9	11 ^a	8
Big problem	4	5	5	7	7	7	6	6

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 3,000 in 2008 and 4,000 in years 2009, 2010, and 2011. Sample sizes for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured samples in the given year.

^b Statistically significantly different (at a 95 percent confidence level) from 2011 within insurance coverage category.

Source: MedPAC-sponsored telephone surveys, conducted in 2008, 2009, 2010, and 2011.

- In 2011, only 6 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported looking for a new primary care physician. This finding suggests that most people are either satisfied with their current physician or did not have a need to look for one.
- Of the 6 percent of Medicare beneficiaries who were looking for a new primary care physician in 2011, 35 percent reported problems finding one—23 percent reporting their problem as “big” plus 12 percent reporting their problem as “small.” Although this number amounts to about 2 percent of the total Medicare population reporting problems, the Commission is concerned about the continuing trend of greater access problems for primary care.

Of the 7 percent of privately insured individuals who were looking for a new primary care physician in 2011, 30 percent reported problems finding one—14 percent reporting their problem as “big” plus 16 percent reporting their problem as “small.”

- For 2011, Medicare beneficiaries and privately insured individuals were more likely to report problems accessing a new primary care physician compared with a new specialist.

Chart 7-6. Access to physician care is better for Medicare beneficiaries compared with privately insured individuals, but minorities in both groups report problems more frequently, 2011

Survey question	Medicare (age 65 or older)			Private insurance (age 50–64)		
	All	White	Minority	All	White	Minority
Unwanted delay in getting an appointment: Among those who needed an appointment, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”						
For routine care						
Never	74% ^a	75%	72% ^a	71% ^a	72% ^b	64% ^{ab}
Sometimes	18 ^a	19	18 ^a	21 ^a	21 ^b	25 ^{ab}
Usually	3	4	3	4	4	4
Always	2 ^a	2 ^{ab}	3 ^{ab}	3 ^a	3 ^{ab}	6 ^{ab}
For illness or injury						
Never	82	83 ^b	75 ^b	79	81 ^b	75 ^b
Sometimes	14 ^a	13 ^{ab}	17 ^b	17 ^a	16 ^a	19
Usually	2	2	2	2	2	3
Always	1	1 ^b	2 ^b	1	1 ^b	2 ^b

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in 2011. Sample sizes for individual questions varied.

^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.

^b Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys, conducted in 2011.

- In 2011, Medicare beneficiaries reported better access to physicians for appointments compared with privately insured individuals age 50 to 64.
- Access varied by race, with minorities more likely than Whites to report access problems in both insurance categories. For example, in 2011, 83 percent of White Medicare beneficiaries reported “never” having to wait longer than they wanted to get an appointment for an illness or injury compared with 75 percent of minority beneficiaries.
- Although minorities experienced more access problems, minorities with Medicare were less likely to experience problems than minorities with private insurance.

Chart 7-7. Differences in access to new physicians are most apparent among minority Medicare and privately insured patients who are looking for a new specialist, 2011

Survey question	Medicare (age 65 or older)			Private insurance (age 50–64)		
	All	White	Minority	All	White	Minority
Looking for a new physician: “In the past 12 months, have you tried to get a new ...?”						
Primary care physician	6%	6%	6%	7%	6%	6%
Specialist	14 ^a	16 ^b	9 ^{ab}	16 ^a	17 ^b	13 ^{ab}
Getting a new physician: Among those who tried to get an appointment with a new physician, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it...”						
Primary care physician						
No problem	65	67	57	68	72	58
Small problem	12	10	19	16	15	19
Big problem	23 ^a	23 ^a	23	14 ^a	12 ^a	18
Specialist						
No problem	84	86 ^b	65 ^{ab}	86	88 ^b	78 ^{ab}
Small problem	8	7	11	8	8	10
Big problem	7	6 ^b	19 ^b	6	5 ^b	11 ^b

Note: Numbers may not sum to 100 percent due to rounding. Missing responses (“Don’t Know” or “Refused”) are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000 in 2011. Sample sizes for individual questions varied.

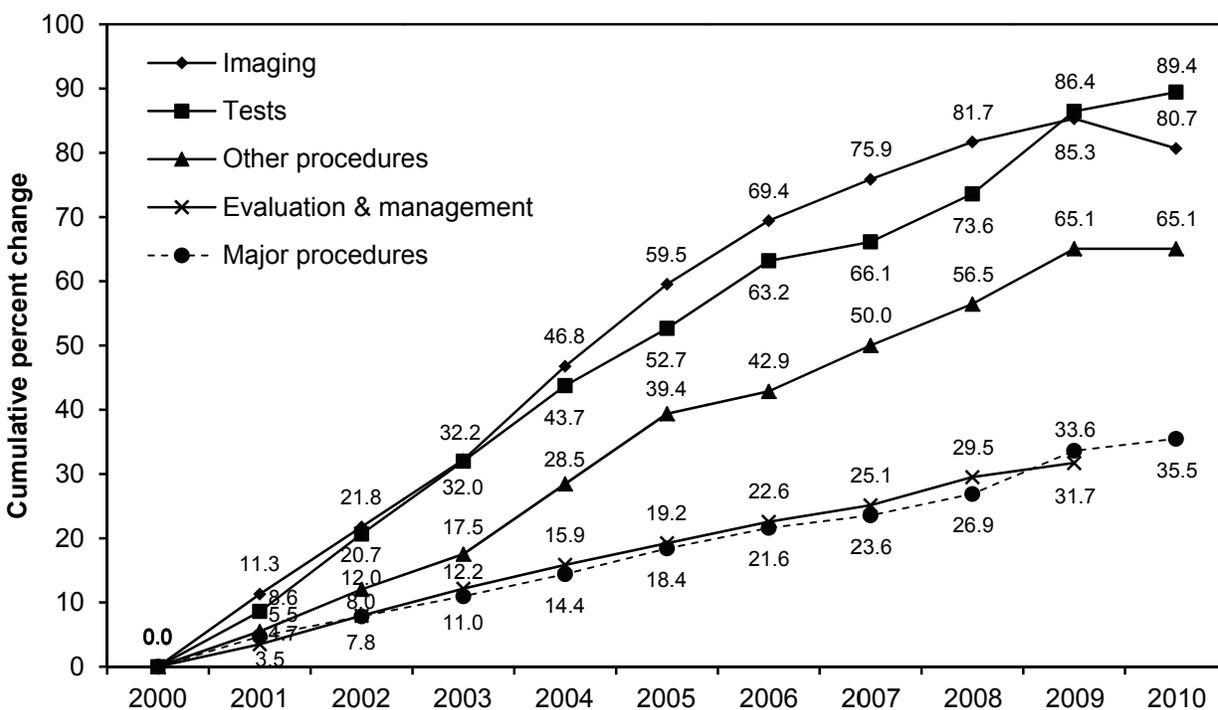
^a Statistically significant difference (at a 95 percent confidence level) between the Medicare and privately insured populations in the given race category.

^b Statistically significant difference (at a 95 percent confidence level) by race within the same insurance category.

Source: MedPAC-sponsored telephone surveys, conducted in 2011.

- Among the small percentage of Medicare beneficiaries and privately insured individuals looking for a new specialist, minorities were more likely than Whites to report problems finding one. For example, in 2011, 86 percent of White Medicare beneficiaries reported “no problem” finding a new specialist, compared with 65 percent of minority beneficiaries.
- Although minorities experienced more access problems, minorities with Medicare were less likely to experience problems than minorities with private insurance.

Chart 7-8. Growth in volume of physician fee schedule services per beneficiary, 2000–2010

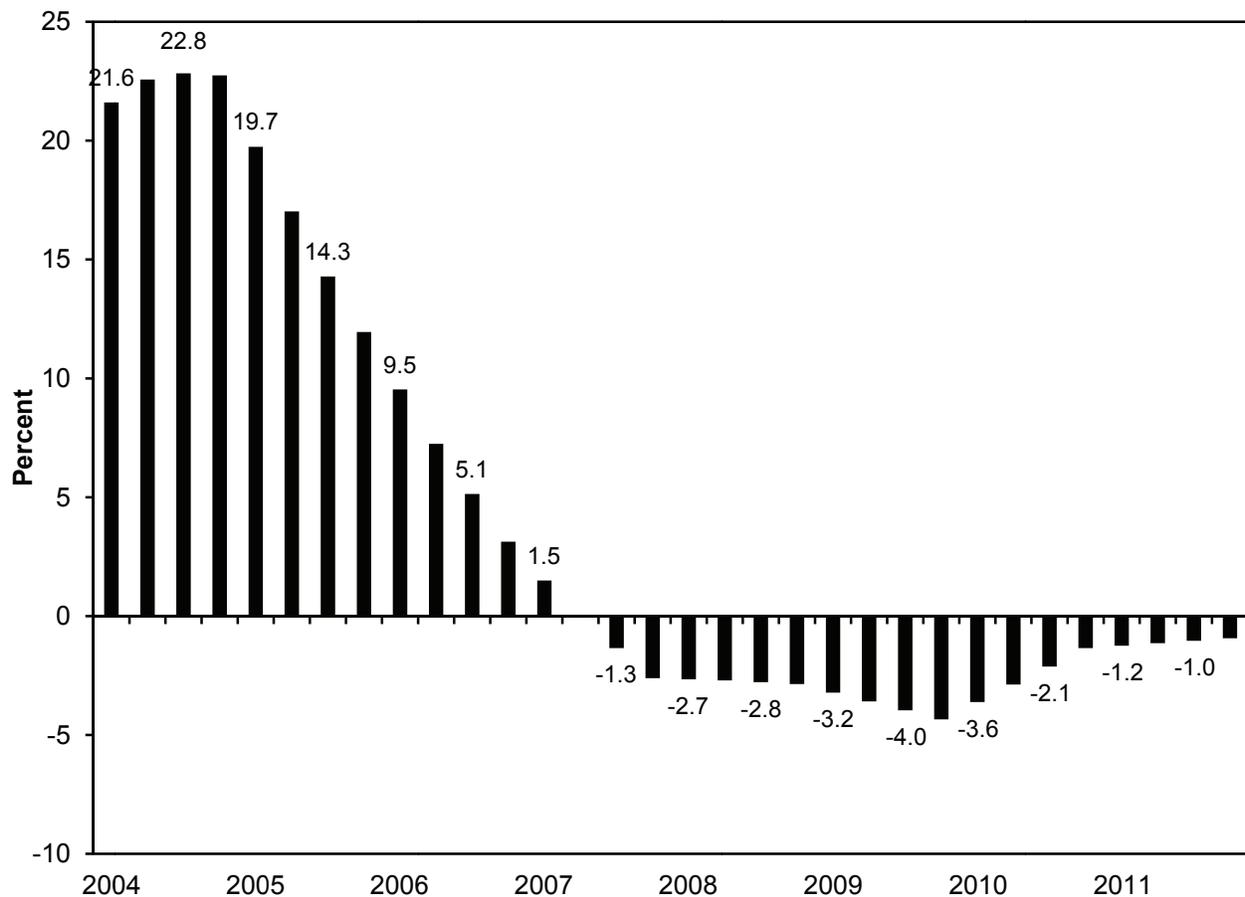


Note: Volume is units of service multiplied by relative value units from the physician fee schedule. Volume for all years is measured on a common scale, with relative value units for 2010. Volume growth for evaluation and management is through 2009 only due to change in payment policy for consultations.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- From 2000 to 2010, the volume of some services furnished by physicians and other professionals grew much more than others.
- The volume of tests grew by 89 percent, the volume of imaging grew by 81 percent, and the volume of “other procedures” (procedures other than major procedures) each grew by 65 percent. The comparable growth rate for major procedures was only 35 percent. While we could not calculate the volume growth rate for evaluation and management (E&M) through 2010 because of a change in payment policy for consultations, the growth rate for E&M through 2009 was similar that for major procedures and, therefore, was much lower than the rates for tests, imaging, and other procedures.
- While the volume of imaging decreased by 2.5 percent from 2009 to 2010, this decrease is small when compared to the increases that had occurred previously. From 2000 to 2009, cumulative growth in the volume of imaging totaled 85 percent.
- Volume growth increases Medicare spending, squeezing other priorities in the federal budget and requiring taxpayers and beneficiaries to contribute more to the Medicare program. Overall volume increases translate directly to growth in both Part B spending and premiums. They are also largely responsible for the negative updates required by the sustainable growth rate formula. Rapid volume growth may be a sign that some services in the physician fee schedule are mispriced.

Chart 7-9. Changes in physicians' professional liability insurance premiums, 2004–2011

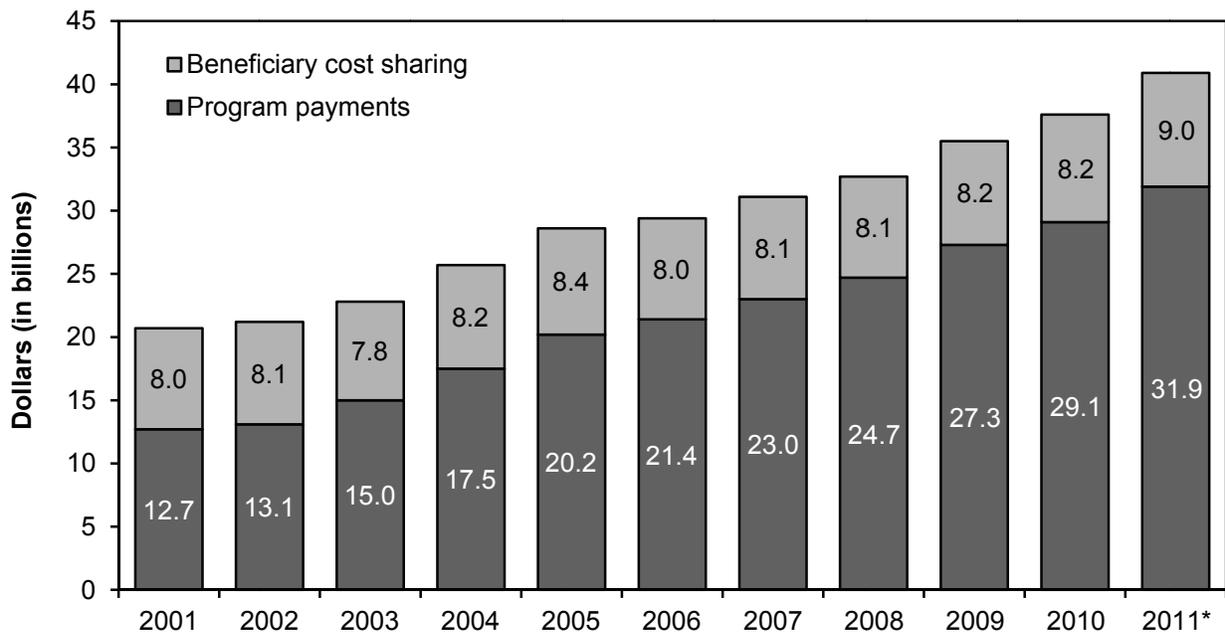


Note: Bars represent a four-quarter moving average percent change.

Source: CMS, Office of the Actuary. Data are from CMS's Professional Liability Physician Premium Survey.

- Professional liability insurance (PLI) accounts for 4.3 percent of total payments under the physician fee schedule. PLI premiums generally follow a cyclical pattern, alternating between periods of low premiums—characterized by high investment returns for insurers and vigorous competition—and high premiums—characterized by declining investment returns and market exit.
- After rapid increases in PLI premiums between 2002 and 2004, premium growth slowed in 2005 and 2006, becoming negative in 2007 and remaining negative through 2011.

Chart 7-10. Spending on all hospital outpatient services, 2001–2011



Note: Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (e.g., ambulance services and durable medical equipment) or those paid on a cost basis (e.g., corneal tissue acquisition and flu vaccines). They do not include payments for clinical laboratory services.
*Estimate.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services (excluding clinical laboratory services) from calendar year 2001 to 2011 increased by 98 percent, reaching \$41.0 billion. The Office of the Actuary projects continued growth in total spending, averaging 9.2 percent per year from 2008 to 2013.
- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent most of the hospital outpatient spending illustrated in this chart, about 91 percent.
- In 2001, the first full year of the outpatient PPS, spending under the PPS was \$19.0 billion, including \$11.3 billion by the program and \$7.6 billion in beneficiary cost sharing. Spending under the outpatient PPS represented 92 percent of the \$20.7 billion in spending on hospital outpatient services in 2001. By 2011, spending under the outpatient PPS is expected to rise to \$37.3 billion (\$29.0 billion program spending; \$8.3 billion beneficiary copayments), which is 91 percent of the \$41.0 billion in spending on outpatient services in 2011. The outpatient PPS accounted for about 5 percent of total Medicare spending by the program in 2011.
- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 22 percent in 2010. Chart 7-14 provides more detail on coinsurance.

Chart 7-11. Most hospitals provide outpatient services

Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
2002	4,210	94%	84%	93%
2004	3,882	94	86	92
2006	3,651	94	86	91
2008	3,607	94	87	91
2010	3,518	95	90	89
2012	3,503	95	91	93*

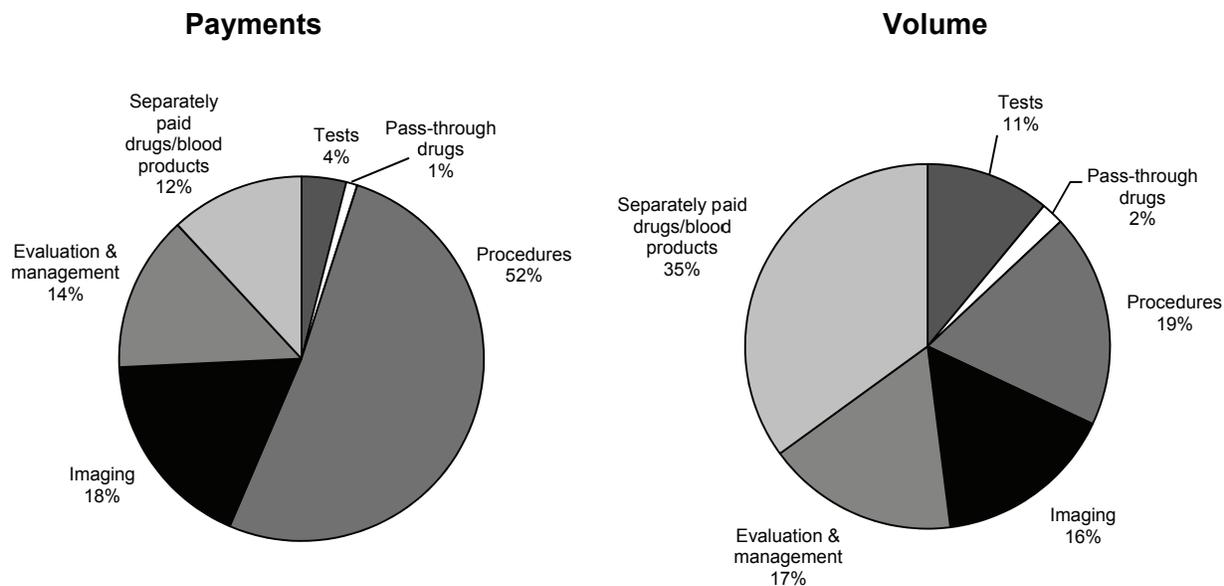
Note: Includes services provided or arranged by short-term hospitals. Excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

*The data source we used in this chart changed the variable for identifying hospitals' provision of emergency services. We believe this change in variable definition makes it appear that the percentage of hospitals providing emergency services increased sharply from 2010 to 2012, but question whether such a large increase actually occurred.

Source: Medicare Provider of Services files from CMS.

- The number of hospitals that furnish services under Medicare's outpatient prospective payment system (PPS) declined from 2002 through 2006, largely due to growth in the number of hospitals converting to critical access hospital status, which allows payment on a cost basis. Since 2006, the number of outpatient PPS hospitals has been more stable. In addition, the percent of hospitals providing outpatient services remained stable; the percent offering outpatient surgery has steadily increased; and the percent offering emergency services has decreased slightly from 2002 through 2010. The increase in the percent providing emergency services in 2012 is likely due to a change in the variable that determines whether a hospital offers emergency services.
- Almost all hospitals in 2012 provide outpatient services (95 percent). The vast majority provide outpatient surgery and emergency services.

Chart 7-12. Payments and volume of services under the Medicare hospital outpatient PPS, by type of service, 2010



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing, but do not include hold-harmless payments to rural hospitals. Services are grouped into evaluation and management, procedures, imaging, and tests, according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicator. Percentages may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the 5 percent standard analytic file of outpatient claims for 2010.

- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.
- The payments for services are distributed differently than volume. For example, procedures account for 52 percent of payments, but only 19 percent of volume.
- Procedures (e.g., endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of payments for services (52 percent), followed by imaging services (18 percent) and evaluation and management services (14 percent).
- In 2010, separately paid drugs and blood products accounted for 12 percent of payments.

Chart 7-13. Hospital outpatient services with the highest Medicare expenditures, 2010

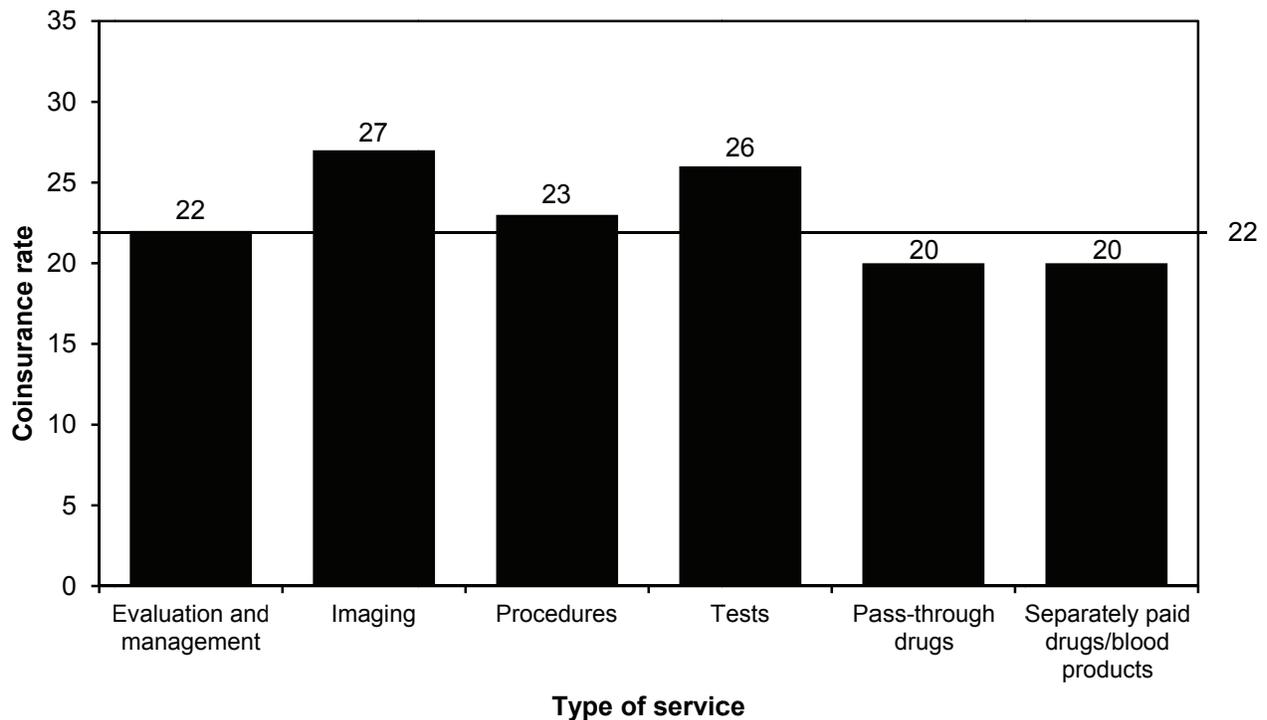
APC Title	Share of payments	Volume (thousands)	Payment rate
Total	46%		
All emergency visits	6	11,589	\$188
All clinic visits	4	20,110	73
Diagnostic cardiac catheterization	3	479	2,677
CT and CTA with contrast composite	3	1,522	627
Cataract procedures with IOL insert	2	528	1,633
Level I plain film except teeth	2	15,890	45
Insertion of cardioverter-defibrillator	2	31	21,909
Lower gastrointestinal endoscopy	2	1,116	612
Level II extended assessment & management composite	2	920	704
Transcatheter placement of intracoronary drug-eluting stents	2	86	7,449
Insertion/replacement/repair of cardioverter-defibrillator leads	2	20	27,728
Coronary or noncoronary angioplasty and percutaneous valvuloplasty	1	192	3,408
IMRT treatment delivery	1	1,189	420
Computed tomography without contrast	1	2,482	195
Level II cardiac imaging	1	638	773
Level II echocardiogram without contrast	1	1,083	450
Level I upper gastrointestinal procedures	1	938	588
CT and CTA without contrast composite	1	1,085	418
Transcatheter placement of intravascular shunts	1	74	6,542
Level II laparoscopy	1	135	3,150
Level III nerve injections	1	876	484
Level III cystourethrosopy and other genitourinary procedures*	1	264	1,716
MRI and magnetic resonance angiography without contrast material	1	1,027	349
MRI and magnetic resonance angiography without contrast followed by contrast	1	607	534
Insertion/replacement/conversion of permanent dual chamber pacemaker	1	34	9,559
Average APC		349	149

Note: APC (ambulatory payment classification), CT (computed tomography), CTA (computed tomography angiography), IOL (intraocular lens), IMRT (intensity-modulated radiation therapy), MRI (magnetic resonance imaging). The payment rates for "All emergency visits" and "All clinic visits" are weighted averages of payment rates from five APCs. The percentages for the specific APCs do not add to the total of 46 because of rounding.
*Did not appear on the list for 2009.

Source: MedPAC analysis of 5 percent analytic files of outpatient claims for calendar year 2010.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 7-14. Medicare coinsurance rates, by type of hospital outpatient service, 2010



Note: Services were grouped into categories of evaluation and management, imaging, procedures, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of the 5 percent standard analytic files of outpatient claims for 2010.

- Before CMS began using the outpatient prospective payment system (PPS), beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payments over time.
- In adopting the outpatient PPS, the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.
- The coinsurance rate is different for each service. Some services, such as imaging, have relatively high rates of coinsurance—27 percent. Other services, such as evaluation and management services, have coinsurance rates of 22 percent.
- In 2010, the average coinsurance rate was about 22 percent.

Chart 7-15. Effects of hold-harmless and SCH transfer payments on hospitals' outpatient revenue, 2008–2010

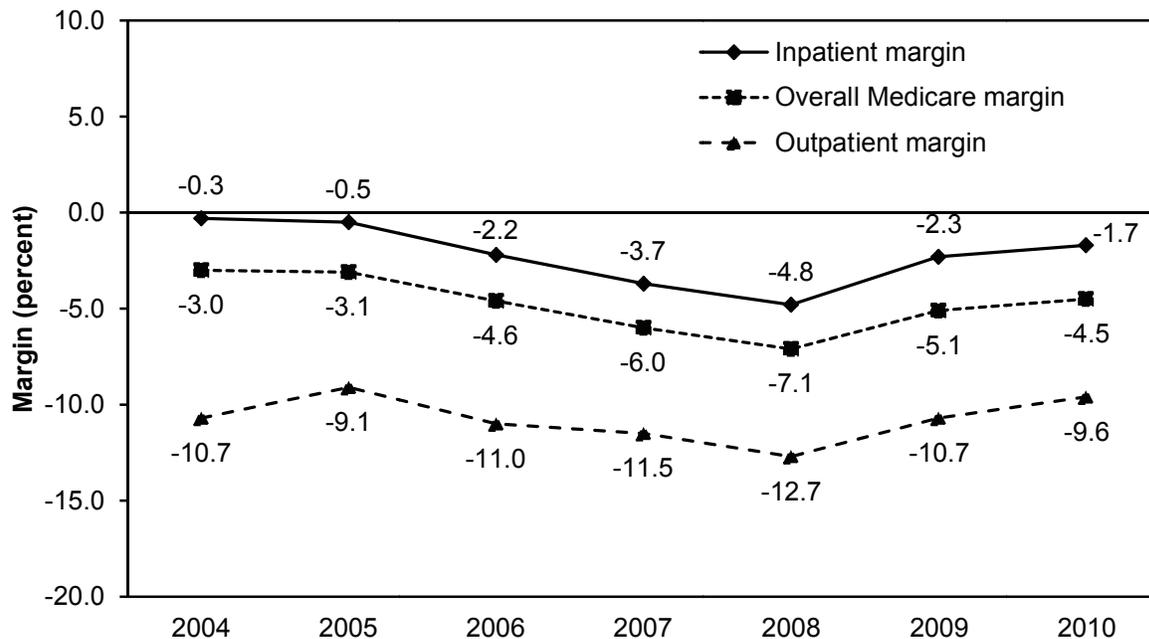
Hospital group	2008		2009		2010	
	Number of hospitals	Share of payments from hold harmless and SCH transfer	Number of hospitals	Share of payments from hold harmless and SCH transfer	Number of hospitals	Share of payments from hold harmless and SCH transfer
All hospitals	3,197	0.2%	3,161	0.3%	3,094	0.4%
Urban	2,271	-0.4	2,245	-0.4	2,212	-0.3
Rural SCHs	381	5.8	383	7.2	363	7.7
Rural ≤100 beds	394	3.0	386	2.9	373	3.1
Other rural	149	-0.4	146	-0.4	145	-0.3
Major teaching	271	-0.3	270	-0.3	267	-0.3
Other teaching	714	-0.1	713	-0.2	712	-0.1
Nonteaching	2,210	0.6	2,177	0.8	2,114	1.0

Note: SCH (sole community hospital). Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Cost Report files from CMS.

- Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000. Previously, Medicare paid for hospital outpatient services on the basis of hospital costs. Recognizing that some hospitals might receive lower payments under the outpatient PPS than under the earlier system, the Congress established transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS.
- Transitional corridor payments expired for most hospitals at the end of 2003. However, some rural hospitals continue to receive a special category of transitional corridor payments called “hold harmless.” Qualifying hospitals receive the greater of the payments they would have received from the previous system or the actual outpatient PPS payments.
- Hospitals that qualified for hold-harmless payments in 2004 and 2005 included SCHs located in rural areas and other small rural hospitals (100 or fewer beds). After 2005, small rural hospitals continued to be eligible for hold-harmless payments, but SCHs no longer qualified. However, in 2006, CMS implemented a policy (the “SCH transfer”) that increased outpatient payments to rural SCHs by 7.1 percent above the standard rates. This policy is budget neutral by reducing payments to all other hospitals by 0.4 percent. Finally, the Congress reestablished hold-harmless payments for SCHs that have 100 or fewer beds in 2009, and extended hold-harmless payments to all SCHs in 2010.
- Hold-harmless payments and the SCH transfer represented 0.2 percent of total outpatient PPS payments for all hospitals in 2008. However, the percentage of total outpatient payments from these policies was 5.8 percent for rural SCHs and 3.0 percent for small rural hospitals. Data from 2009 and 2010 indicate transfer and hold-harmless payments to rural SCHs were 7.2 percent of their outpatient revenue in 2009 and 7.7 percent in 2010. Small rural hospitals continued to benefit from hold-harmless payments in 2009 and 2010. These payments were 2.9 percent of their total outpatient payments in 2009 and 3.1 percent in 2010.

Chart 7-16. Medicare hospital outpatient, inpatient, and overall Medicare margins, 2004–2010

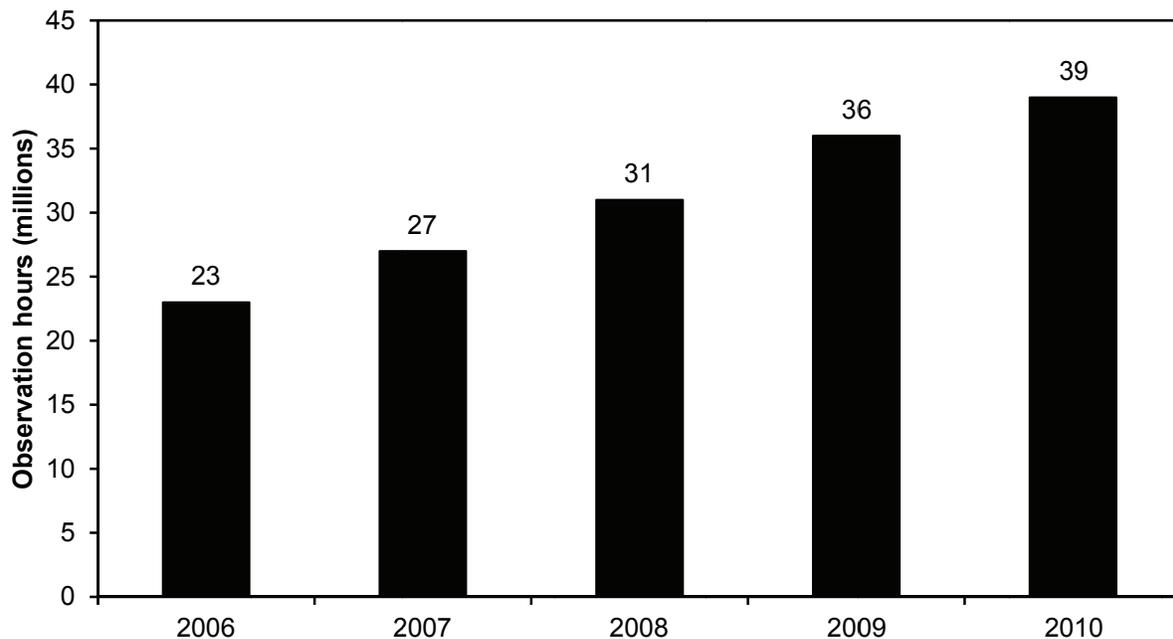


Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation services (not paid under the prospective payment system); hospital-based skilled nursing facilities and home health services; and graduate medical education.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Hospital outpatient margins vary. In 2010, while the aggregate margin was –9.6 percent, 25 percent of hospitals had margins of –20.7 percent or lower, and 25 percent had margins of 2.8 percent or higher. Outpatient margins also differed widely across hospital categories.
- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. Hospitals allocate overhead to all services, so we generally consider costs and payments overall.
- The improved outpatient margin in 2010 may be due to relatively low cost growth. After increasing from 2004 to 2005, the outpatient margin declined in 2006, reflecting a change in Medicare’s reimbursement for Part B drugs and an end to hold-harmless payments to SCHs (which were reestablished in 2009). The margin declined again in 2007 and 2008, which may be partly due to lower hold-harmless payments for hospitals that still qualify for them. The improved margin in 2009 may be due to low cost growth and expansion of hold-harmless payments to sole community hospitals.

Chart 7-17. Number of observation hours has increased, 2006–2010



Source: MedPAC analysis of Limited Data Set claims for the outpatient prospective payment system, 2006–2010.

- Hospitals use observation care to determine whether a patient should be hospitalized for inpatient care or sent home.
- Medicare began providing separate payments to hospitals for some observation services on April 1, 2002. Previously, the observation services were packaged into the payments for the emergency room or clinic visits that occur with observation care.
- The number of observation hours (both packaged and separately paid) has increased substantially from about 23 million in 2006 to 39 million in 2010. Before 2006, it was difficult to count the total number of observation hours because hospitals were not required to record on claims the number of hours for packaged observation hours.

Chart 7-18. Number of Medicare-certified ASCs increased by 33 percent, 2004–2011

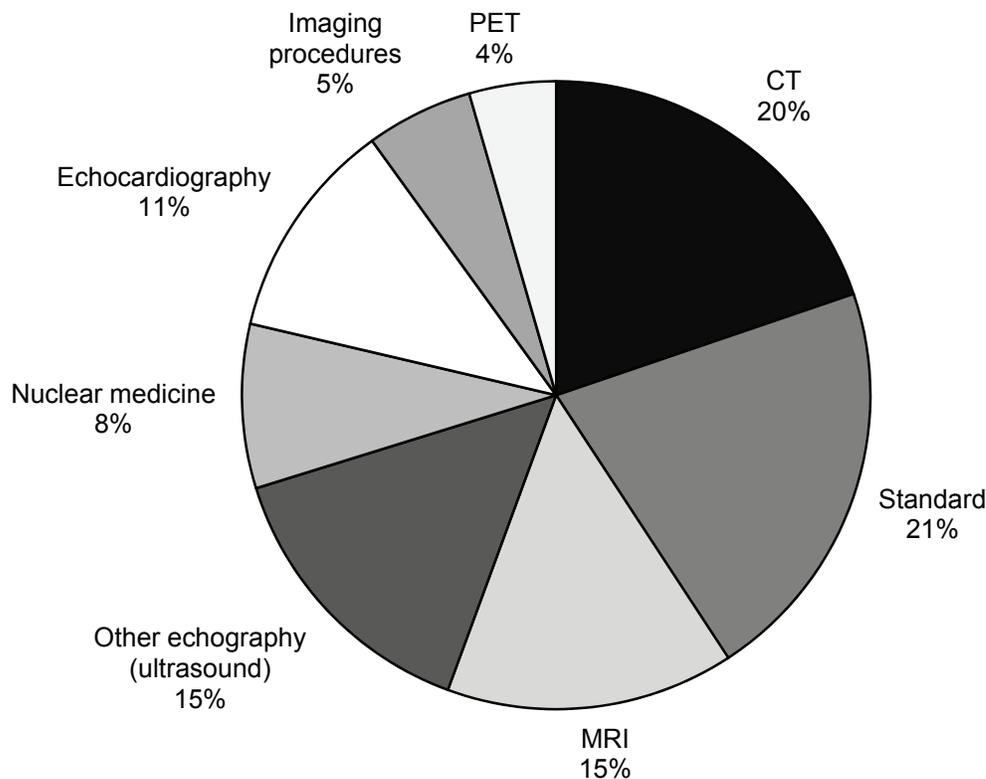
	2004	2005	2006	2007	2008	2009	2010	2011
Medicare payments (billions of dollars)	\$2.5	\$2.7	\$2.8	\$2.9	\$3.1	\$3.2	\$3.3	\$3.5
Number of centers	4,033	4,328	4,567	4,838	5,045	5,157	5,252	5344
New centers	367	354	328	345	281	218	189	153
Exiting centers	81	59	89	74	74	106	94	61
Net percent growth in number of centers from previous year	6.7%	7.3%	5.5%	5.9%	4.3%	2.2%	1.8%	1.8%
Percent of all centers that are:								
For profit	96	96	96	96	96	96	97	97
Nonprofit	4	4	4	4	4	3	3	3
Urban	91	91	91	91	91	91	91	91
Rural	9	9	9	9	9	9	9	9

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2011 are preliminary and subject to change. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of provider of services files from CMS, 2011. Payment data are from CMS, Office of the Actuary.

- ASCs are entities that furnish only outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum facility standards.
- In 2008, Medicare began using a new payment system for ASC services that is based on the hospital outpatient prospective payment system. ASC rates are less than hospital outpatient rates. In contrast to the old ASC system, which had only nine procedure groups, the new system has several hundred procedure groups.
- Total Medicare payments for ASC services increased by 4.9 percent per year, on average, from 2004 through 2011. Payments per fee-for-service beneficiary grew by 5.3 percent per year during this period. Between 2010 and 2011, total payments rose by 3.4 percent and payments per beneficiary grew by 2.5 percent.
- The number of Medicare-certified ASCs grew at an average annual rate of 4.1 percent from 2004 through 2011. Each year from 2004 through 2011, an average of 279 new Medicare-certified facilities entered the market, while an average of 80 closed or merged with other facilities.

Chart 7-19. Medicare spending for imaging services under the physician fee schedule, by type of service, 2010

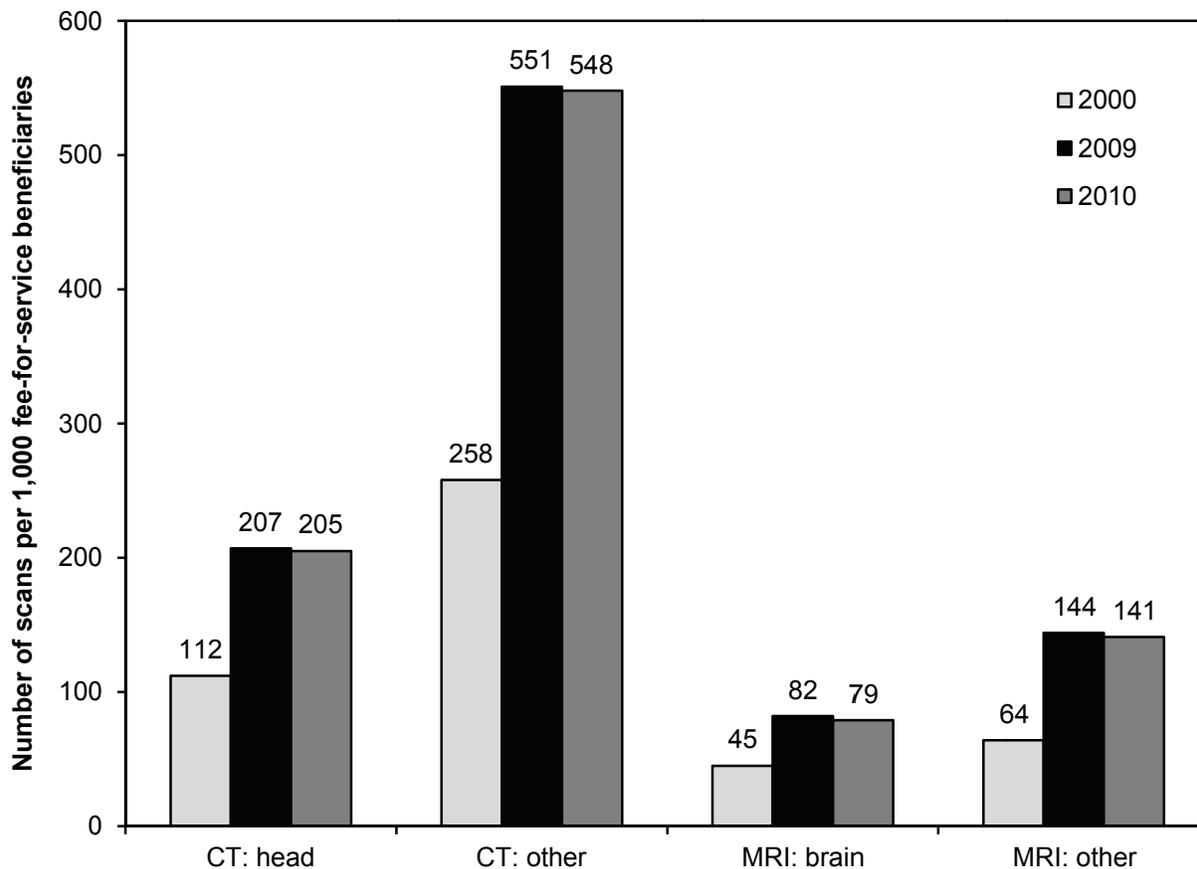


Note: CT (computed tomography), MRI (magnetic resonance imaging), PET (positron emission tomography). Standard imaging includes chest, musculoskeletal, and breast X-rays. Imaging procedures include stereoscopic X-ray guidance for delivery of radiation therapy, fluoroguide for spinal injection, and other interventional radiology procedures. Medicare payments include program spending and beneficiary cost sharing for physician fee schedule imaging services. Payments include carrier-priced codes, but exclude radiopharmaceuticals. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary file from CMS, 2010.

- Over one-third of Medicare spending for imaging under the physician fee schedule in 2010 was for CT and MRI studies.
- Medicare and beneficiaries spent a total of \$10.9 billion for imaging services under the physician fee schedule in 2010. Spending declined from \$11.6 billion in 2009 (–5.4 percent). The decline in spending was largely due to the creation of new comprehensive codes for myocardial perfusion imaging (a type of nuclear medicine study), CMS’s adoption of more current practice expense data from a new survey of practitioners, and an increase in the equipment use rate assumption for expensive imaging equipment, such as MRI and CT machines.
- Although spending for imaging services declined from 2009 to 2010, this decrease is small compared with the increases that occurred over the prior decade. From 2000 to 2009, cumulative growth in imaging spending totaled 80 percent (67 percent per fee-for-service beneficiary).

Chart 7-20. Rapid growth in the number of CT and MRI scans per 1,000 beneficiaries, 2000-2010



Note: CT (computed tomography), MRI (magnetic resonance imaging). Data include physician fee schedule imaging services.

Source: MedPAC analysis of 100 percent physician/supplier procedure summary files from CMS, 2000, 2009, and 2010.

- The number of CT and MRI scans per 1,000 fee-for-service beneficiaries grew rapidly from 2000 to 2009. Despite a slight decline from 2009 to 2010, the number of studies in 2010 was still much higher than the level in 2000.
- For example, the number of CT scans of parts of the body other than the head more than doubled from 2000 to 2010 (from 258 per 1,000 beneficiaries to 548), despite a slight drop from 2009 to 2010.
- Similarly, the number of MRI studies of parts of the body other than the brain more than doubled from 2000 to 2010.

Web links. Ambulatory care

Physicians

- For more information on Medicare's payment system for physician services, see MedPAC's Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_Physician.pdf

- Chapter 4 of the MedPAC March 2012 Report to the Congress and Appendix A of the June 2012 Report to the Congress provide additional information on physician services.

http://www.medpac.gov/chapters/Mar12_Ch04_CORRECTED.pdf

http://www.medpac.gov/chapters/Jun12_AppA.pdf

- MedPAC's congressionally mandated report, *Assessing Alternatives to the Sustainable Growth Rate (SGR) System*, examines the SGR and analyzes alternative mechanisms for controlling physician expenditures under Medicare.

http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf

- Congressional testimony by the chairman and executive director of MedPAC discusses payment for physician services in the Medicare program. This includes:

Payments to selected fee-for-service providers (May 15, 2007)

http://www.medpac.gov/documents/051507_WandM_Testimony_MedPAC_FFS.pdf

Options to improve Medicare's payments to physicians (May 10, 2007)

http://www.medpac.gov/documents/051007_Testimony_MedPAC_physician_payment.pdf

Assessing alternatives to the sustainable growth rate system (March 6, 2007)

http://www.medpac.gov/documents/030607_W_M_testimony_SGR.pdf

Assessing alternatives to the sustainable growth rate system (March 6, 2007)

http://www.medpac.gov/documents/030607_E_C_testimony_SGR.pdf

Assessing alternatives to the sustainable growth rate system (March 1, 2007)

http://www.medpac.gov/documents/030107_Finance_testimony_SGR.pdf

MedPAC recommendations on imaging services (July 18, 2006)

http://www.medpac.gov/documents/071806_Testimony_imaging.pdf

Medicare payment to physicians (July 25, 2006)

http://www.medpac.gov/documents/072506_Testimony_physician.pdf

- The 2011 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

<http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>

- The Government Accountability Office issued a report in August 2009 about access to physician services within Medicare.

<http://www.gao.gov/new.items/d09559.pdf>

- The Center for Studying Health System Change also conducts research on patient access to health care.

<http://www.hschange.org>

Hospital outpatient services

- For more information on Medicare's payment system for hospital outpatient services, see MedPAC's Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_opd.pdf

- Chapter 3 of the MedPAC March 2012 Report to the Congress provides information on the status of hospital outpatient departments including supply, volume, profitability, and cost growth.

http://www.medpac.gov/chapters/Mar12_Ch03.pdf

- Section 2A of the MedPAC March 2006 Report to the Congress provides information on the current status of hold-harmless payments and other special payments for rural hospitals.

http://www.medpac.gov/publications/congressional_reports/Mar06_Ch02a.pdf

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- For more information on Medicare's payment system for ambulatory surgical centers, see MedPAC's Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_ASC.pdf

- Chapter 5 of the MedPAC March 2012 Report to the Congress provides additional information on ambulatory surgical centers.

http://www.medpac.gov/chapters/Mar12_Ch05.pdf

SECTION

8

Post-acute care
Skilled nursing facilities
Home health agencies
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1. Number of post-acute care providers increased or remained stable in 2011

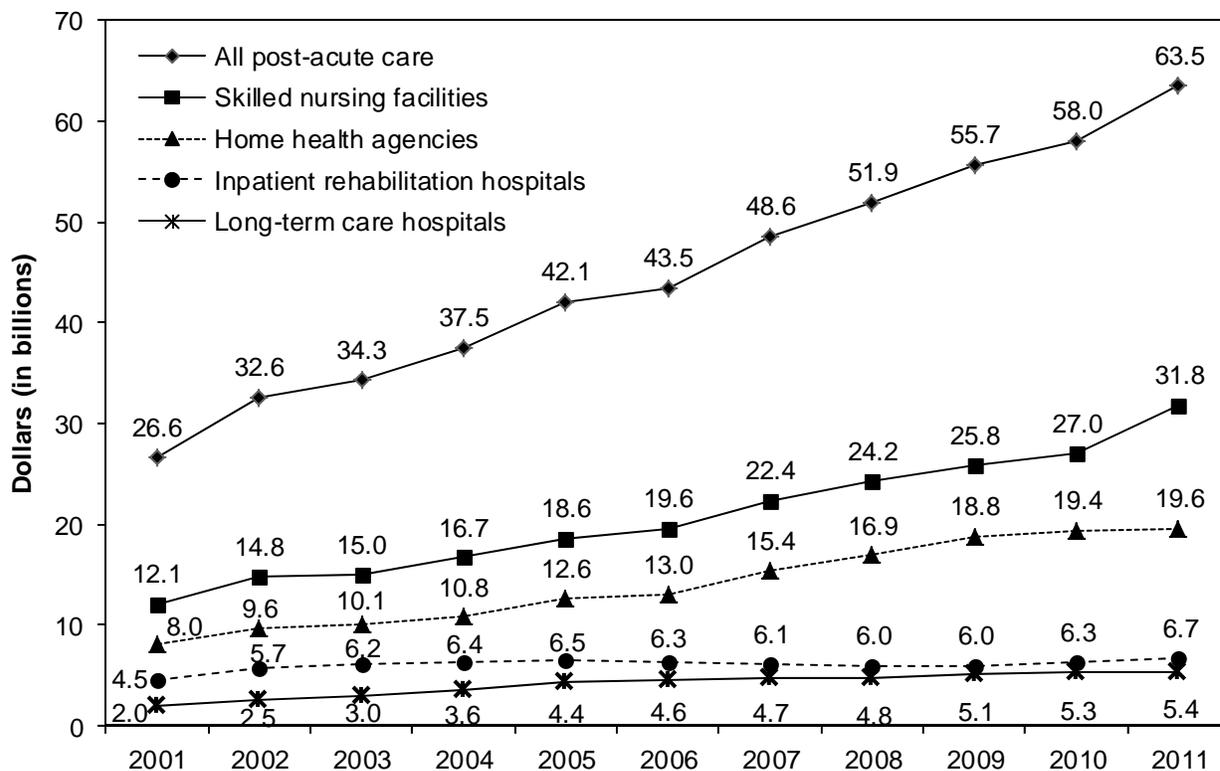
	2003	2004	2005	2006	2007	2008	2009	2010	2011	Average annual percent change 2003-2011	Percent change 2010-2011
Home health agencies	7,342	7,804	8,314	8,955	9,404	10,040	10,961	11,654	12,026	6.4%	3.2%
Inpatient rehabilitation facilities	1,207	1,221	1,235	1,225	1,202	1,202	1,196	1,179	1,165	-0.4	-1.2
Long-term care hospitals	334	366	392	398	406	425	435	437	436	3.4	-0.2
Skilled nursing facilities	15,144	15,156	15,185	15,178	15,207	15,190	15,190	15,207	15,161	0.1	-0.3

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification's Providing Data Quickly system for 2003-2011 (home health agencies, long-term care hospitals, and skilled nursing facilities) and CMS Provider of Service data (inpatient rehabilitation facilities).

- The number of home health agencies has increased substantially since 2003. The number of agencies increased by over 350 in 2011. The growth in new agencies is concentrated in a few areas of the country.
- The number of inpatient rehabilitation facilities (rehabilitation hospitals and rehabilitation units) declined slightly in 2011.
- In spite of a moratorium on new long-term care hospitals (LTCHs) beginning in October 2007, the number of these facilities continued to grow through 2010. The number of LTCHs declined by one facility in 2011.
- The total number of skilled nursing facilities has remained about the same since 2003, but the mix of facilities continues to shift from hospital-based to freestanding facilities. Hospital-based facilities make up 6 percent of all facilities, down from 9 percent in 2003.

Chart 8-2. Medicare’s spending on home health care and skilled nursing facilities fueled growth in post-acute care expenditures



Note: These numbers are program spending only and do not include beneficiary copayments.

Source: CMS Office of the Actuary.

- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part due to expanded enrollment in managed care, whose spending is not included in this chart.
- Despite the slower growth, spending on all post-acute care still grew close to 9 percent between 2010 and 2011, fueled primarily by increases in skilled nursing facility expenditures.
- Fee spending on inpatient rehabilitation hospitals has declined since 2005 and 2008, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less intensive settings. However, spending on inpatient rehabilitation hospitals has increased since 2009.
- FFS spending on skilled nursing facilities increased sharply in 2011, reflecting providers’ responses to the implementation of the new case-mix groups (resource utilization groups, version IV) beginning October 2010.

Chart 8-3. Since 2006, the share of Medicare stays and payments going to freestanding SNFs and for-profit SNFs has increased

Type of SNF	Facilities		Medicare-covered stays		Medicare payments	
	2006	2010	2006	2010	2006	2010
All SNFs	100%	100%	100%	100%	100%	100%
Freestanding	92	94	89	93	94	96
Hospital based	8	6	11	7	6	4
Urban	67	70	79	81	81	83
Rural	33	30	21	19	19	17
For profit	68	70	67	70	73	74
Nonprofit	26	25	29	25	24	22
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 percent due to rounding or missing information about facility characteristics.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files 2006–2010.

- Freestanding SNFs made up 94 percent of facilities in 2010.
- Freestanding SNFs treated 93 percent of stays (up 4 percentage points from 2006) and accounted for 96 percent of Medicare payments.
- For-profit facilities made up 70 percent of facilities in 2010. Between 2006 and 2010, for-profit SNFs' share of Medicare-covered stays increased 3 percentage points and payments increased 1 percentage point.
- Urban SNFs' share of facilities, Medicare-covered stays, and payments increased between 2006 and 2010.

Chart 8-4. Small declines in SNF days and admissions between 2009 and 2010

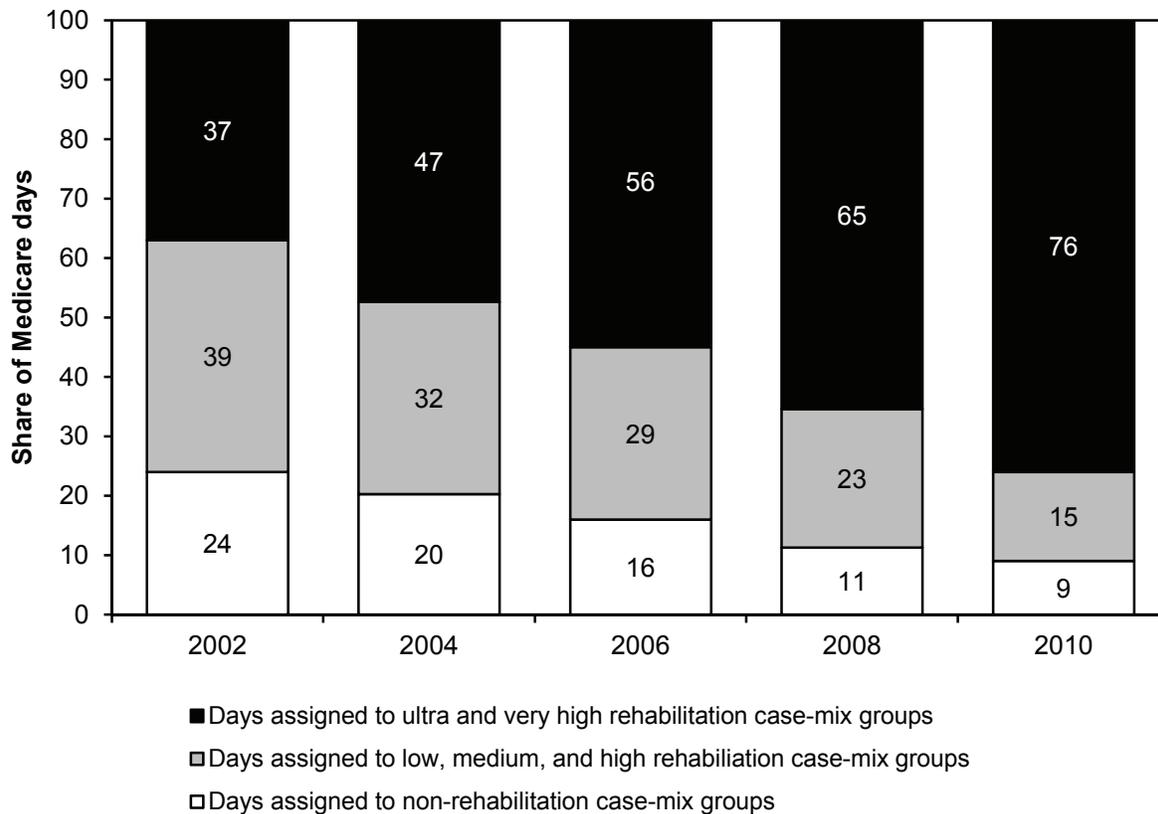
	2008	2009	2010	Change 2009–2010
Volume per 1,000 fee-for-service beneficiaries				
Covered admissions	73	72	71	-1.4%
Covered days	1,977	1,963	1,938	-1.3
Covered days per admission	27.0	27.3	27.1	-0.7

Note: SNF (skilled nursing facility). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Research, Development and Information.

- Between 2009 and 2010, covered days and admissions declined. The decline in admissions is expected because inpatient hospital stays, which are required for Medicare coverage of skilled nursing facility services, also declined. Despite the reductions, covered days and covered days per admission were higher than in 2006 (not shown).

Chart 8-5. Case mix in freestanding SNFs shifted toward highest rehabilitation case-mix groups and away from other categories



Note: SNF (skilled nursing facility). Days are for freestanding SNFs with valid cost reports. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of freestanding SNF cost reports.

- In 2010, rehabilitation resource utilization groups (RUGs) accounted for 91 percent of all Medicare days in SNFs. The two highest payment rehabilitation case-mix groups (ultra high and very high) made up 76 percent of all days (compared with 37 percent in 2002). Days not classified into a rehabilitation case-mix group declined from 24 percent in 2002 to 9 percent in 2010.
- Some of the growth in total rehabilitation days may be explained by a shift in the site of care from inpatient rehabilitation facilities to SNFs. It also could reflect the payment incentives to furnish the services necessary to get patients classified into higher paying rehabilitation RUGs.

Chart 8-6. Freestanding SNF Medicare margins have exceeded 10 percent for seven years, and have increased steadily since 2005

Type of SNF	2004	2005	2006	2007	2008	2009	2010
All	13.7%	13.1%	13.3%	14.7%	16.6%	18.0%	18.5%
Urban	13.2	12.6	13.1	14.5	16.3	17.9	18.5
Rural	16.1	15.2	14.3	15.5	18.0	18.7	18.4
For profit	16.1	15.2	15.7	17.2	19.1	20.2	20.7
Nonprofit	3.5	4.5	3.5	4.1	6.9	9.6	9.5
Government*	N/A						

Note: SNF (skilled nursing facility), N/A (not applicable).

*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of freestanding SNF cost reports.

- Although aggregate Medicare margins for freestanding SNFs have varied over the past 7 years, they have exceeded 10 percent every year since 2001 (early years not shown).
- Aggregate Medicare margins increased from 2009 to 2010 due to costs per day growing more slowly than payments per day. The growth in payments reflected the increased share of days classified into the highest paying resource utilization groups.
- Examining the distribution of 2010 margins, one-half of freestanding SNFs had margins of 18.9 percent or more (not shown). One-quarter had Medicare margins at or below 9 percent and one-quarter had margins of 26.9 percent or higher.

Chart 8-7. Freestanding SNFs with relatively low costs and relatively high quality maintained high Medicare margins

Characteristic	SNFs with relatively low costs and good quality (10 percent)	Other SNFs
Performance in 2009		
Relative* community discharge rate	1.38	0.95
Relative* rehospitalization rate	0.83	1.02
Relative* cost per day	0.90	1.02
Medicare margin	22.0%	18.2%
Performance in 2010		
Relative* cost per day	0.92	1.01
Medicare margin	22.0%	18.9%
Total margin	5.1	3.8
Medicaid share of facility days	59%	63%

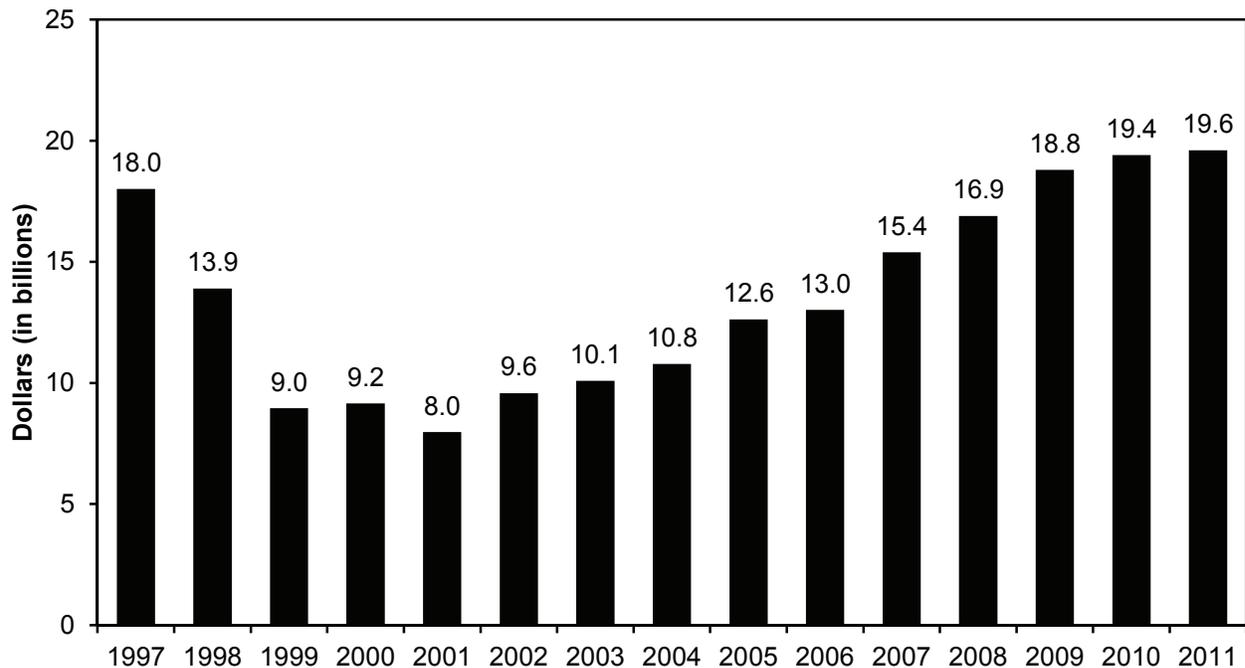
Note: SNF (skilled nursing facility). SNFs with relatively low costs and good quality were those in the lowest third of the distribution of cost per day, in the top third for one quality measure, and not in the bottom third for the other quality measure. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for five conditions (congestive heart failure, respiratory infection, urinary tract infection, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Increases in rates of discharge to the community indicate improved quality; increases in rehospitalization rates for the five conditions indicate worsening quality. Quality measures were calculated for all facilities with more than 25 stays.

*Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2006–2009 and Medicare cost report data for 2006–2010.

- Freestanding SNFs can have relatively low costs and provide good quality of care while maintaining high margins.
- In 2009, compared with average SNFs, relatively efficient SNFs had community discharge rates that were 38 percent higher and rehospitalization rates that were 17 percent lower.
- In 2010, relatively efficient SNFs had costs per day that were 8 percent lower than average SNFs. Relatively efficient SNFs had median Medicare margins in 2010 of 22 percent compared with a median margin for other SNFs of 18.9 percent.
- Relatively efficient SNFs were more likely to be located in a rural area and more likely to be nonprofit than other SNFs (not shown).

Chart 8-8. Spending for home health care, 1997–2011



Source: CMS, Office of the Actuary, 2012.

- Medicare home health care spending grew at an average annual rate of 20 percent from 1992 to 1997. During that period, the payment system was cost based. Eligibility had been loosened just before this period, and enforcing the program’s standards became more difficult. Providers delivering billing for fraudulent or uncovered services were also a significant factor in the increase in expenditures.
- Spending began to fall after 1997, concurrent with the introduction of the interim payment system (IPS) based on costs with limits, tighter eligibility, and increased scrutiny from the Office of Inspector General.
- In October 2000, the prospective payment system (PPS) replaced the IPS. At the same time, eligibility for the benefit broadened slightly.
- Home health care has risen rapidly under PPS. Spending has risen by about 10 percent a year between 2001 and 2009, but growth slowed in 2010 and 2011.

Chart 8-9. Provision of home health care changed after the prospective payment system started

	1997	2001	2010	Percent change	
				1997–2001	2001–2010
Number of visits (in millions)	258	74	125	–71%	69%
Visit type (percent of total)					
Home health aide	48%	25%	16%		
Skilled nursing	41	50	52		
Therapy	10	24	33		
Medical social services	1	1	1		
Visits per home health patient	73	33	36	–55	9

Note: The prospective payment system began in October 2000. Totals may not sum to 100 percent due to rounding.

Source: Home health Standard Analytic File; Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2002.

- The types and amount of home health care services that beneficiaries receive have changed. In 1997, home health aide services were the most frequently provided visit type, and beneficiaries who used home health care received an average of 73 visits.
- CMS began to phase in the interim payment system in October 1997 to stem the rise in spending for home health services and implemented a prospective payment system (PPS) in 2000 (see Chart 8-8). By 2001, total visits dropped by 72 percent, and average visits per user had dropped to 33. The increase in visits per user between 2001 and 2010 reflects home health users getting more episodes. The mix of services changed as well, with skilled nursing and therapy visits now accounting for over 80 percent of all services. Since PPS was implemented, the number of users and episodes has risen rapidly (see Chart 8-10).

Chart 8-10. Trends in provision of home health care

	2002	2005	2010	Average annual percent change 2002–2010
Number of users (in millions)	2.5	3.0	3.4	3.9%
Percent of beneficiaries who used home health	7.2%	8.1%	9.6%	3.6
Episodes (in millions)	4.1	5.2	6.8	6.6
Episodes per home health patient	1.6	1.8	2.0	2.6
Visits per home health patient	31	32	36	2.2
Average payment per episode	\$2,335	\$2,465	\$2,839	2.5

Source: MedPAC analysis of the home health Standard Analytic File.

- Under the prospective payment system, in effect since 2000, the number of users and the number of episodes have risen significantly. In 2010, 3.4 million beneficiaries used the home health benefit.
- The number of home health episodes increased rapidly from 2002 to 2010. The number of beneficiaries using home health has also increased since 2002, but at a lower rate than the growth in episodes.
- The number of visits per home health patient increased from 31 in 2002 to 36 in 2010. This increase is primarily due to a rise in the number of home health episodes per patient.

Chart 8-11. Margins for freestanding home health agencies

	2009	2010	Percent of agencies 2010
All	18.2%	19.4%	100%
Geography			
Mostly urban	18.5	19.4	86
Mostly rural	17.0	19.7	14
Type of control			
For profit	19.8	20.7	87
Nonprofit	13.0	15.3	13
Volume quintile			
First	8.9	9.9	20
Second	10.2	11.6	20
Third	14.9	13.9	20
Fourth	18.1	18.2	20
Fifth	20.3	22.1	20

Note: Agencies characterized as urban or rural based on the residence of the majority of their patients. Agencies with outlier payments that exceeded 10 percent of Medicare revenues are excluded from the reported statistics.

Source: MedPAC analysis of 2009–2010 Cost Report files.

- In 2010, about 80 percent of agencies had positive margins (not shown in chart). These estimated margins indicate that Medicare's payments are above the costs of providing services to Medicare beneficiaries for both rural and urban home health agencies (HHAs).
- These margins are for freestanding HHAs, which composed about 85 percent of all HHAs in 2010. HHAs are also based in hospitals and other facilities.
- HHAs that served mostly urban patients in 2010 had an aggregate average margin of 19.4 percent; those that served mostly rural patients had an aggregate average margin of 19.7 percent. The 2009 margin is consistent with the historically high margins the home health industry has experienced under the prospective payment system. The aggregate average margin from 2001 to 2009 averaged 17.5 percent, indicating that most agencies have been paid well in excess of their costs under prospective payment.
- For-profit agencies in 2010 had an aggregate average margin of 20.7 percent, and nonprofit agencies had an aggregate average margin of 15.3 percent.
- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2010 have an aggregate average margin of 9.9 percent, while those in the highest quintile have an aggregate average margin of 22.1 percent.

Chart 8-12. Most common types of inpatient rehabilitation facility cases, 2011

Type of case	Share of cases
Stroke	19.8%
Fracture of the lower extremity	13.9
Major joint replacement	10.5
Debility	10.4
Neurological disorders	10.3
Brain injury	7.5
Other orthopedic	7.0
Cardiac conditions	5.1
Spinal cord injury	4.3
Other	11.1

Note: Other includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS (January through June of 2011).

- In 2011, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing close to 20 percent of cases, up from 2004, when stroke represented fewer than 17 percent of cases.
- Major joint replacement cases represented close to 11 percent of IRF admissions in 2011, down from 24 percent of cases in 2004, when major joint replacement was the most common IRF Medicare case type.

Chart 8-13. Volume of IRF FFS patients declined slightly in 2010

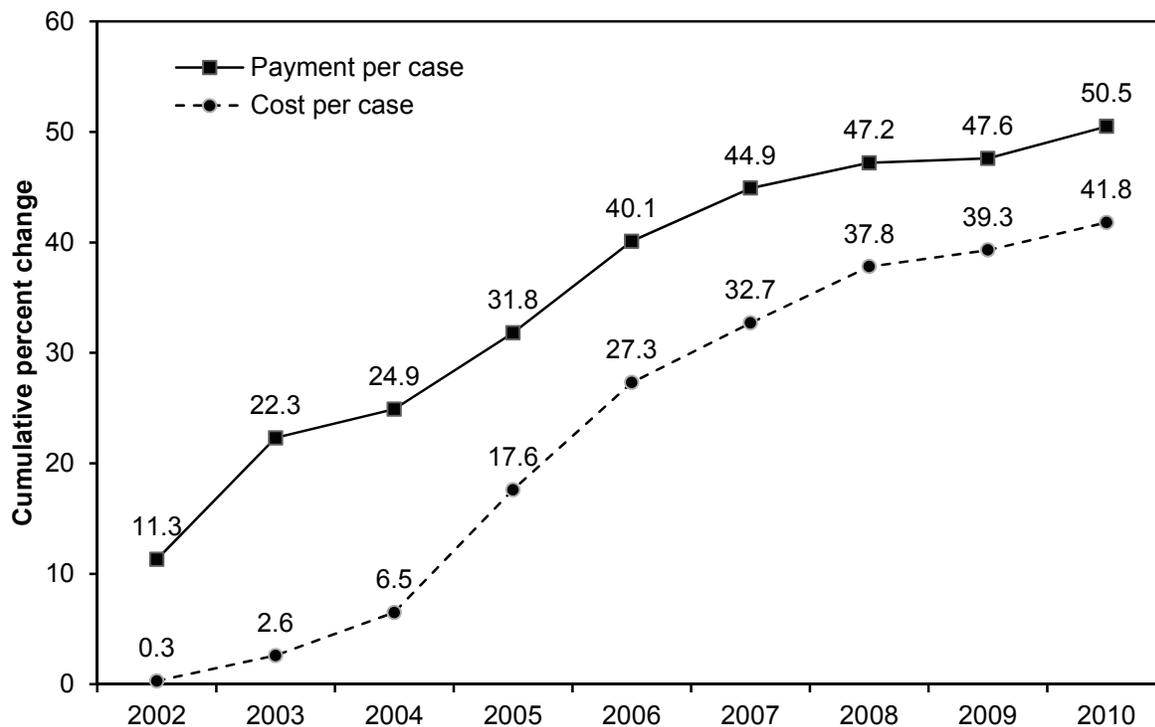
	2004	2008	2009	2010	Average annual percent change 2004–2009	Percent change 2009–2010
Number of IRF cases	495,000	356,000	364,000	359,000	–6.2%	–1.3%
Unique patients per 10,000 FFS beneficiaries	123.0	91.5	93.0	91.1	–5.8	–2.1
Payment per case	\$13,290	\$16,646	\$16,552	\$17,085	5.2	3.2
Medicare spending (in billions)	\$6.43	\$5.95	\$6.03	\$6.32	–0.3	4.8
Average length of stay (in days)	12.7	13.3	13.1	13.1	0.6	0

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Numbers of cases reflect Medicare FFS utilization only.

Source: MedPAC analysis of MedPAR data from CMS. Total Medicare spending for IRF services from CMS Office of the Actuary.

- IRF volume is measured by the number of IRF cases and the number of unique patients per 10,000 beneficiaries, which controls for changes in FFS enrollment.
- IRF volume declined after 2004 when enforcement of the compliance threshold (60 percent rule) was renewed.
- Medicare FFS spending on IRFs declined between 2004 and 2008 as more IRFs complied with the 60 percent rule and more Medicare beneficiaries enrolled in Medicare Advantage plans.
- The number of IRF cases increased between 2008 and 2009. This increase was due to an increase in both the number of unique beneficiaries receiving IRF care and an increase in the number of beneficiaries with more than one IRF stay in a year.
- In 2010, the number of IRF cases declined slightly by 1.3 percent. This decline may in part be due to the revised coverage criteria for an IRF stay that went into effect in January 2010. The revised coverage criteria did not change, but more clearly defined, which Medicare beneficiaries are appropriate for IRFs. Therefore, some patients that IRFs would have admitted previously might not have met the more specific coverage criteria in 2010.

Chart 8-14. Overall IRFs' payments per case have risen faster than costs since implementation of the PPS in 2002



Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system). Data are from consistent two-year cohorts of IRFs. Costs are not adjusted for changes in case mix.

Source: MedPAC analysis of cost report data from CMS.

- Since implementation of the PPS in 2002, overall Medicare payments per case have increased faster than costs, even when costs per case grew rapidly between 2004 and 2006 as a result of enforcement of the compliance threshold.
- These trends in Medicare per case payments and costs are reflected in IRFs' Medicare margins, shown in Chart 8-15.

Chart 8-15. Inpatient rehabilitation facilities' Medicare margin by type, 2002–2010

	2002	2004	2006	2008	2009	2010
All IRFs	10.8%	16.7%	12.4%	9.5%	8.4%	8.8%
Hospital based	6.1	12.2	9.7	4.1	0.4	-0.2
Freestanding	18.5	24.7	17.5	18.2	20.3	21.4
Urban	11.3	16.9	12.6	9.7	8.6	9.1
Rural	5.9	13.9	10.6	7.6	6.3	5.5
Nonprofit	6.5	12.8	10.7	5.6	2.3	2.0
For profit	18.5	24.4	16.3	16.7	19.0	19.8

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of cost report data from CMS.

- The aggregate Medicare margin increased rapidly during the first two years (2002–2004) of the IRF prospective payment system (PPS). Aggregate margins rose from just under 2 percent in 2001 to almost 17 percent in 2004.
- From 2004 to 2009, margins declined, but remained high. This decline was largely due to reductions in patient volume over this time period that resulted in fewer patients among whom to distribute fixed costs. The 2007 to 2009 margin decrease was mainly a result of a zero update to the base rates for half of 2008 and for all of 2009 that resulted in Medicare payment rates remaining at 2007 levels.
- Margins increased in 2010 from 8.4 percent in 2009 to 8.8 percent in 2010.
- Freestanding and for-profit IRFs had substantially higher aggregate Medicare margins than hospital-based and nonprofit IRFs, continuing a trend that began with implementation of the IRF PPS in 2002.

Chart 8-16. The top 25 MS–LTC–DRGs made up nearly two-thirds of LTCH discharges in 2010

MS-LTC DRG	Description	Discharges	Percentage	Change 2008-2010
207	Respiratory system diagnosis with ventilator support 96+ hours	16,024	11.9%	6.9%
189	Pulmonary edema and respiratory failure	11,148	8.3	27.5
871	Septicemia or severe sepsis without ventilator support 96+ hours with MCC	7,474	5.5	15.3
177	Respiratory infections & inflammations with MCC	5,067	3.8	16.8
592	Skin ulcers with MCC	3,568	2.6	-10.9
949	Aftercare with CC/MCC	3,046	2.3	-18.8
208	Respiratory system diagnosis with ventilator support <96 hours	2,851	2.1	14.7
193	Simple pneumonia and pleurisy with MCC	2,847	2.1	5.6
190	Chronic obstructive pulmonary disease with MCC	2,654	2.0	3.8
539	Osteomyelitis with MCC	2,415	1.8	26.9
573	Skin graft and/or debridement for skin ulcer or cellulitis with MCC	2,059	1.5	7.7
862	Postoperative and post-traumatic infections with MCC	2,033	1.5	21.6
314	Other circulatory system diagnosis with MCC	1,983	1.5	33.4
919	Complications of treatment with MCC	1,950	1.4	17.5
682	Renal failure with MCC	1,937	1.4	11.4
166	Other respiratory system OR procedures with MCC	1,911	1.4	12.9
559	Aftercare, musculoskeletal system and connective tissue with MCC	1,877	1.4	-3.4
291	Heart failure and shock with MCC	1,821	1.4	7.9
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,656	1.2	17.1
593	Skin ulcers with CC	1,646	1.2	-36.4
178	Respiratory infections and inflammations with CC	1,644	1.2	-16.3
602	Cellulitis with MCC	1,593	1.2	40.0
870	Septicemia or severe sepsis with ventilator support 96+ hours	1,592	1.2	47.7
603	Cellulitis without MCC	1,432	1.1	2.3
194	Simple pneumonia and pleurisy with CC	1,285	1.0	-22.3
	Top 25 MS–LTC–DRGs	83,513	62.0	8.5
	Total	134,683	100.0	2.9

Note: MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS–LTC–DRGs are the case-mix system for LTCHs.
Columns may not sum due to rounding.

Source: MedPAC analysis of MedPAR data from CMS.

- Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2010, the top 25 MS–LTC–DRGs accounted for nearly two-thirds of all cases.
- The most frequent diagnosis in LTCHs in 2010 was respiratory system diagnosis with ventilator support for more than 96 hours. Ten of the top 25 diagnoses, representing 35 percent of all cases, were respiratory conditions.

Chart 8-17. LTCH spending per FFS beneficiary continues to rise

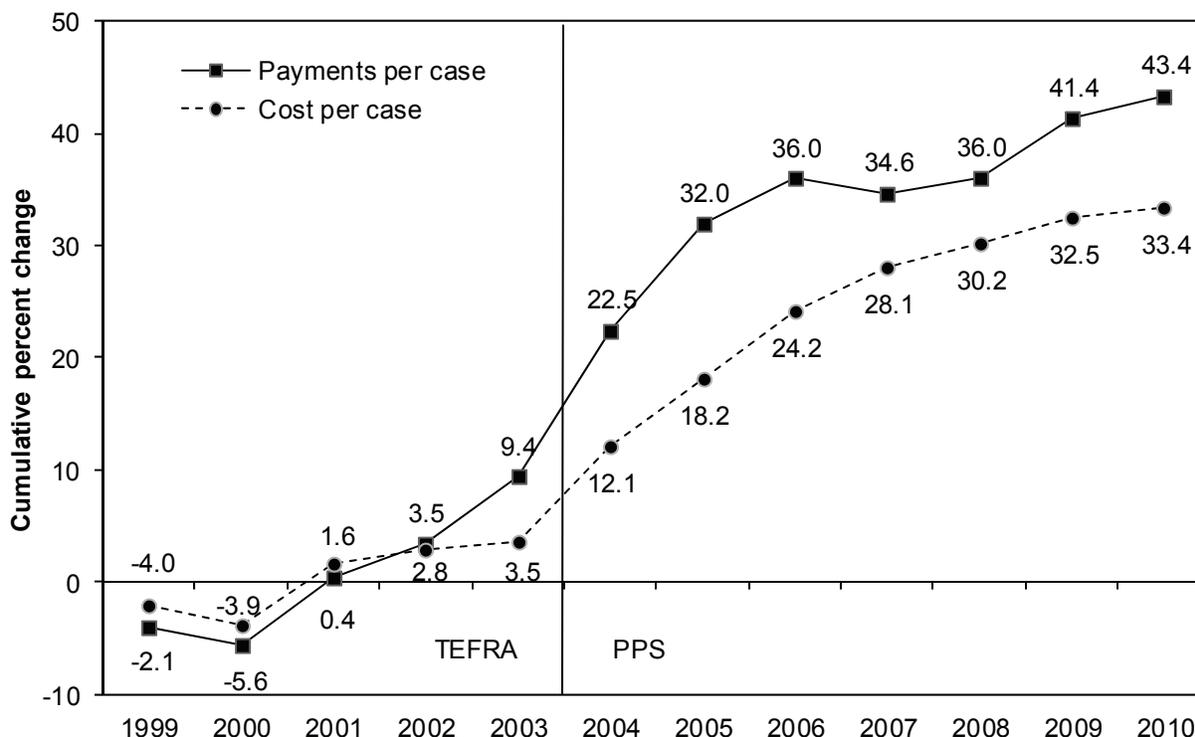
	2003	2004	2005	2006	2007	2008	2009	2010	Average annual change		
									2003–2005	2005–2009	2009–2010
Cases	110,396	121,955	134,003	130,164	129,202	130,869	131,446	134,683	10.2%	-0.5%	2.5%
Cases per 10,000 FFS beneficiaries	30.8	33.4	36.4	36.0	36.3	37.0	37.1	38.4	8.8	0.5	3.5
Spending (in billions)	\$2.7	\$3.7	\$4.5	\$4.5	\$4.5	\$4.6	\$4.9	\$5.2	29.1	2.2	6.0
Spending per FFS beneficiary	\$75.2	\$101.3	\$122.2	\$124.3	\$126.5	\$130.2	\$138.3	\$148.1	27.5	3.1	7.1
Payment per case	\$24,758	\$30,059	\$33,658	\$34,859	\$34,769	\$35,200	\$37,465	\$38,582	16.6	2.7	3.0
Length of stay (in days)	28.8	28.5	28.2	27.9	26.9	26.7	26.4	26.6	-1.0	-1.6	0.8

Note: LTCH (Long-term care hospital), FFS (fee for service)

Source: MedPAC analysis of MedPAR data from CMS.

- Between 2009 and 2010, the number of LTCH cases per FFS beneficiary rose 3.5 percent. Medicare LTCH spending per fee-for-service beneficiary rose more than twice as much over the same period (7.1 percent).

Chart 8-18. LTCHs' per case payments rose more quickly than costs in 2010



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

- Payment per case increased rapidly after the PPS was implemented, climbing an average 16.6 percent per year between 2003 and 2005. Cost per case also increased rapidly during this period, albeit at a somewhat slower pace.
- Between 2005 and 2008, growth in cost per case outpaced that for payments, as regulatory changes to Medicare's payment policies for LTCHs slowed growth in payment per case to an average of 1.4 percent per year.
- After the Congress delayed implementation of some of CMS's recent regulations, payments per case climbed 5.3 percent between 2008 and 2009, about twice as much as the growth in costs. However, between 2009 and 2010, payment growth slowed to 2 percent, while cost growth was held under 1 percent.

Chart 8-19. LTCHs' aggregate Medicare margin rose in 2010

Type of LTCH	Share of discharges	2003	2004	2005	2006	2007	2008	2009	2010
All	100%	5.2%	9.0%	11.9%	9.8%	4.8%	3.5%	5.6%	6.4%
Urban	96	5.2	9.2	11.9	10.0	5.1	3.8	5.9	6.7
Rural	5	4.5	2.6	10.1	4.9	-0.7	-3.3	-2.8	-0.5
Freestanding	70	5.6	8.4	11.3	9.3	4.4	3.1	4.7	5.6
Hospital within hospital	30	4.2	10.6	13.1	10.8	5.8	4.4	7.6	8.1
Nonprofit	16	1.7	6.9	9.1	6.4	1.3	-2.5	-0.6	-1.2
For profit	83	6.3	10.0	13.1	10.9	5.9	5.1	7.2	8.0
Government	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not available). Share of discharges column groupings may not sum to 100 percent due to rounding or missing data. Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of cost report data from CMS.

- After implementation of the prospective payment system, LTCHs' Medicare margins increased rapidly, from 5.2 percent in 2003 to 11.9 percent in 2005. Margins then fell as growth in payments per case leveled off. In 2009, however, LTCH margins began to increase again, reaching 6.4 percent in 2010.
- Financial performance in 2010 varied across LTCHs. Margins increased between 2009 and 2010 for all types of LTCHs except nonprofits, whose margins fell from -0.6 percent to -1.2 percent. The aggregate Medicare margin for for-profit LTCHs (which accounted for 83 percent of all Medicare discharges from LTCHs) was 8.0 percent. Rural LTCHs' aggregate margin was -0.5 percent, compared with 6.7 percent for their urban counterparts. Rural providers account for about 5 percent of LTCHs discharges, caring for a smaller volume of patients on average, which may result in poorer economies of scale.

Chart 8-20. LTCHs in the top quartile of Medicare margins in 2010 had much lower costs

Characteristics	High-margin quartile	Low-margin quartile
Mean Medicare margin	20.9%	-11.3%
Mean total discharges (all payers)	576	444
Medicare patient share	68%	64%
Medicaid patient share	8	5
Occupancy rate	74	62
Average length of stay (in days)	26	27
Adjusted CMI	0.9743	0.8981
Mean per discharge:		
Standardized costs	\$26,660	\$36,251
Total Medicare payment*	\$38,557	\$38,157
High-cost outlier payments	\$1,316	\$5,005
Share of:		
Cases that are SSOs	26%	34%
Medicare cases from primary-referring ACH	35	41
LTCHs that are for-profit	90	64

Note: LTCH (long-term care hospital), CMI (case-mix index), SSO (short-stay outlier), ACH (acute care hospital). Includes only established LTCHs—those that filed valid cost reports in both 2009 and 2010. Top margin quartile LTCHs were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. Adjusted case-mix indices have been adjusted for differences in SSOs across facilities. Average primary referring ACH referral share indicates the mean share of patients referred to LTCHs in the quartile from the ACH that refers the most patients to the LTCH. Government providers were excluded.

*Includes outlier payments.

Source: MedPAC analysis of LTCH cost reports and MedPAR data from CMS.

- A quarter of all LTCHs had margins in excess of 20.9 percent, while another quarter had margins below -11.3 percent.
- Lower per discharge costs, rather than higher payments, drove the differences in financial performance between LTCHs with the lowest and highest Medicare margins. Low-margin LTCHs had standardized costs per discharge that were 36 percent higher than high-margin LTCHs (\$36,251 vs. \$26,660). Low-margin LTCHs served more patients overall and had a lower average occupancy rate; thus, they benefit less from economies of scale.
- High-cost outlier payments per discharge for low-margin LTCHs were almost four times those of high-margin LTCHs (\$5,005 vs. \$1,316). At the same time, SSOs made up a larger share of low-margin LTCHs' cases. Low-margin LTCHs thus cared for disproportionate shares of patients who are high-cost outliers and patients who have shorter stays.

Web links. Post-acute care

Skilled nursing facilities

- Chapter 7 of MedPAC's March 2012 Report to the Congress provides information about the supply, quality, service use, and Medicare margins for skilled nursing facilities. Chapter 7 of MedPAC's June 2008 Report to the Congress provides information about alternative designs for Medicare's prospective payment system that would more accurately pay providers for their skilled nursing facility services. *Medicare payment basics: Skilled nursing facility payment system* provides a description of how Medicare pays for skilled nursing facility care.

http://www.medpac.gov/chapters/Mar12_Ch07.pdf

http://www.medpac.gov/chapters/Jun08_Ch07.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_SNF.pdf

- The official Medicare website provides information on skilled nursing facilities, including the payment system and other related issues.

<http://www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPPS/>

Home health services

- Chapter 8 of MedPAC's March 2012 Report to the Congress provide information on home health services. *Medicare payment basics: Home health care services payment system* provides a description of how Medicare pays for home health care.

http://www.medpac.gov/chapters/Mar12_Ch08.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_HHA.pdf

- The official Medicare website provides information on the quality of home health care and additional information on new policies, statistics, and research as well as information on home health spending and use of services.

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html>

Inpatient rehabilitation facilities

- Chapter 9 of MedPAC's March 2011 Report to the Congress provides information on inpatient rehabilitation facilities. *Medicare payment basics: Rehabilitation facilities (inpatient) payment system* provides a description of how Medicare pays for inpatient rehabilitation facility services.

http://www.medpac.gov/chapters/Mar12_Ch09.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_IRF.pdf

- CMS provides information on the inpatient rehabilitation facility prospective payment system.

<http://www.cms.gov/medicare/medicare-fee-for-service-payment/InpatientRehabFacPPS/>

Long-term care hospitals

- Chapter 10 of MedPAC's March 2011 Report to the Congress provides information on long-term care hospitals. *Medicare payment basics: Long-term care hospital services payment system* provides a description of how Medicare pays for long-term care hospital services.

http://www.medpac.gov/chapters/Mar12_Ch10.pdf

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_LTCH.pdf

- CMS also provides information on long-term care hospitals, including the long-term care hospital prospective payment system.

<http://www.cms.gov//medicare/medicare-fee-for-service-payment/LongTermCareHospitalPPS/>

SECTION

9

Medicare Advantage

Chart 9-1. MA plans available to virtually all Medicare beneficiaries

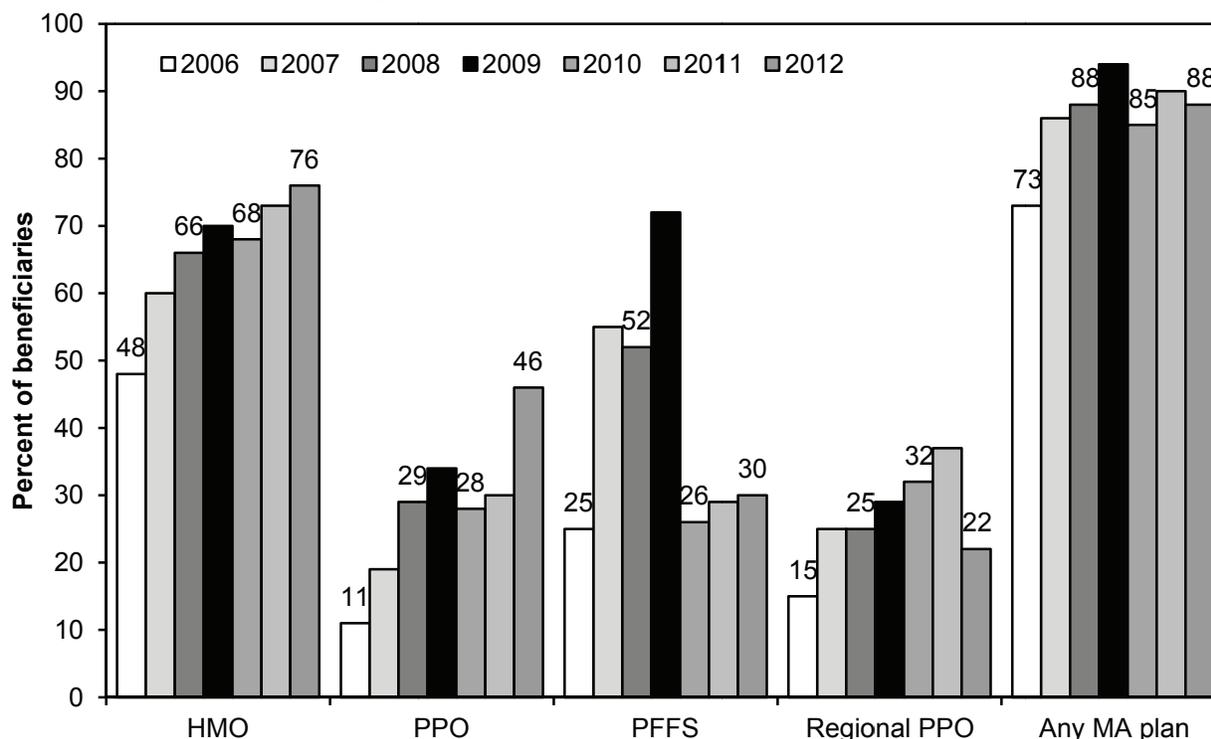
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35
2009	88	91	99	100	100	34
2010	91	86	99	100	100	21
2011	92	86	99	63	100	12
2012	93	76	99	60	100	12

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost-based plans, employer-only plans, and certain demonstration plans).

Source: MedPAC analysis of plan finder data from CMS.

- There are four types of plans, three of which are CCPs. Local CCPs include local PPOs and HMOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional CCPs (regional plans are required by statute to be PPOs) cover entire state-based regions and have networks that may be looser than the ones required of local PPOs. Since 2011, PFFS plans, which previously were not CCPs, are required to have networks in areas with two or more CCPs. In areas where there are not two or more CCPs, PFFS plans are not required to have networks and enrollees are free to use any Medicare provider.
- Local CCPs are available to 93 percent of Medicare beneficiaries in 2012—up from 67 percent in 2005. Regional PPOs are available to 76 percent of beneficiaries. The availability of MA PFFS plans has declined from 100 percent of beneficiaries in 2010 to 60 percent of beneficiaries in 2012. The decline is due to recent provider network requirements in most of the country. For the past seven years, virtually 100 percent of Medicare beneficiaries have had MA plans available, up from 84 percent in 2005.
- The number of plans from which beneficiaries may choose in 2012 is about the same as last year. In 2012, beneficiaries can choose from an average of 12 plans operating in their counties. This number has decreased after peaking in 2008 and 2009, reflecting CMS's 2010 effort to reduce the number of duplicative plans and plans with small enrollment and the network requirements for PFFS plans.

Chart 9-2. Access to zero-premium plans with MA drug coverage, 2006–2012

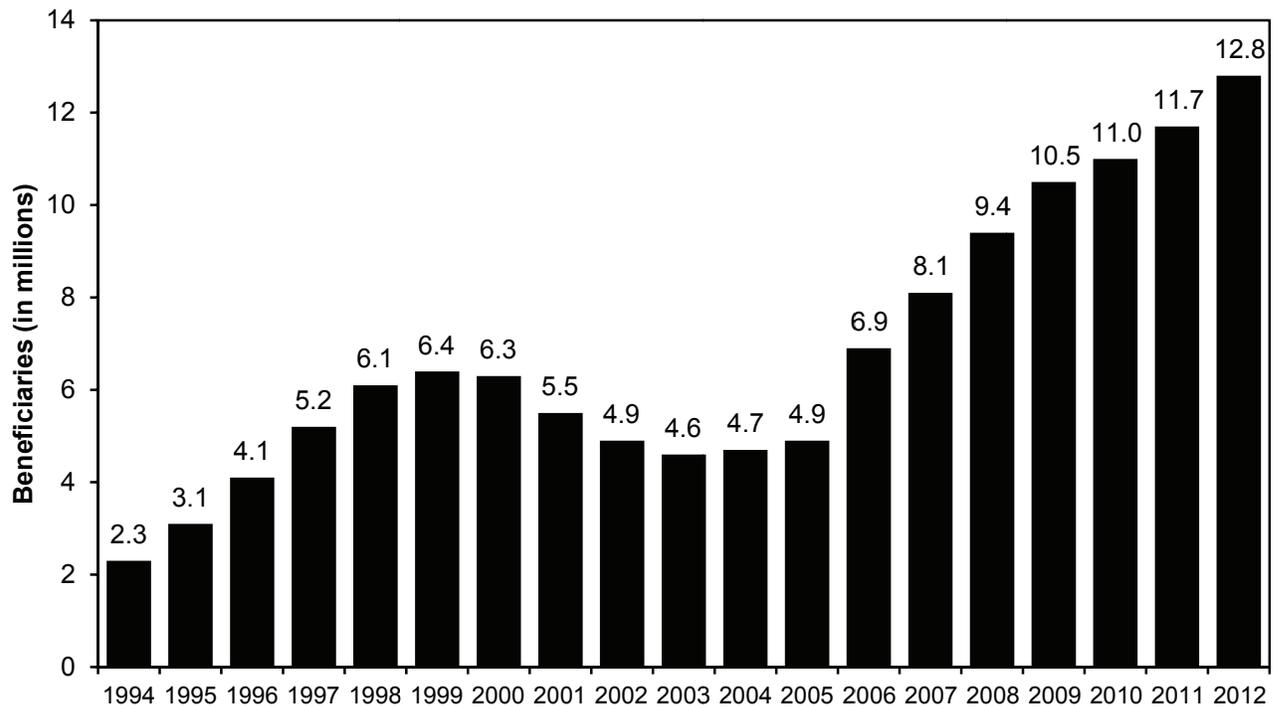


Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of bid and plan finder data from CMS.

- Across all plan types, the availability of “zero-premium” plans—plans with no premium payments other than the Medicare Part B premium—has ranged from 85 percent to 94 percent since 2007. Most beneficiaries can obtain a Medicare Advantage–Prescription Drug (MA–PD) plan, an MA plan that includes Part D drug coverage, for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2012, 88 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 90 percent in 2011.
- Seventy-six percent of beneficiaries have zero-premium MA–PD HMOs available. MA–PD PPOs without premiums are less widely available, but are available to 46 percent of beneficiaries in 2012, up from 30 percent in 2011. However, zero-premium regional PPOs are less available than they have been in the past. PFFS plans offering zero premiums and Part D drug coverage are available to 30 percent of beneficiaries in 2012.
- In most cases, MA plan enrollees continue paying their Medicare Part B premium, but some MA–PD plans use rebate dollars to reduce or eliminate their enrollees’ Part B premium obligation.

Chart 9-3. Enrollment in MA plans, 1994–2012



Note: MA (Medicare Advantage).

Source: Medicare managed care contract reports and monthly summary reports, CMS.

- Medicare enrollment in private health plans paid on an at-risk capitated basis is at an all-time high at 12.8 million enrollees (26 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, and then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003.

Chart 9-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)				Percentage change 2011–2012
	February 2009	February 2010	February 2011	February 2012	
Local CCPs	7,625	8,534	9,993	11,382	14%
Regional PPOs	377	760	1,132	930	–18
PFFS	2,353	1,657	588	518	–12

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include health maintenance organizations and local PPOs.

Source: CMS health plan monthly summary reports.

- Enrollment in local CCPs grew by 14 percent over the past year. Enrollment in regional PPOs and in PFFS plans declined. Combined enrollment in the three types of plans grew by 10 percent from February 2011 to February 2012.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2012

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					Total
		HMO	Local PPO	Regional PPO	PFFS	Cost	
US total	48,799	17%	6%	2%	1%	1%	27%
Alabama	871	14	6	1	0	0	22
Alaska	68	0	0	0	0	0	1
Arizona	959	34	3	1	1	0	38
Arkansas	547	7	3	3	4	0	16
California	4,934	35	1	0	0	0	37
Colorado	655	26	3	0	1	4	34
Connecticut	581	16	4	1	0	0	21
Delaware	155	3	1	0	0	0	5
Florida	3,470	25	2	7	0	0	35
Georgia	1,296	6	10	4	4	0	24
Hawaii	215	15	12	14	0	4	45
Idaho	239	10	16	0	3	1	31
Illinois	1,889	6	3	0	0	0	10
Indiana	1,037	2	9	7	2	0	19
Iowa	527	6	6	1	1	2	14
Kansas	444	4	5	0	3	0	12
Kentucky	784	3	7	6	1	1	17
Louisiana	709	22	1	2	1	0	26
Maine	273	9	6	0	0	0	16
Maryland	815	3	2	0	0	3	9
Massachusetts	1,092	15	2	1	0	0	18
Michigan	1,709	11	13	1	1	0	26
Minnesota	811	15	5	2	0	26	47
Mississippi	511	5	3	2	2	0	11
Missouri	1,029	15	5	1	2	0	23
Montana	175	0	9	1	7	0	16
Nebraska	285	6	3	1	3	1	13
Nevada	372	27	3	2	1	0	33
New Hampshire	228	1	2	0	2	0	5
New Jersey	1,364	13	1	0	0	0	14
New Mexico	325	19	8	0	1	0	28
New York	3,067	23	7	2	1	0	32
North Carolina	1,546	11	4	2	3	0	19
North Dakota	110	0	1	0	3	7	11
Ohio	1,949	15	16	4	0	1	37
Oklahoma	619	11	3	0	2	0	16
Oregon	644	21	20	0	0	0	42
Pennsylvania	2,329	24	14	0	1	0	39
Puerto Rico	685	63	7	0	0	0	70
Rhode Island	187	33	1	2	0	0	36
South Carolina	807	3	6	5	3	0	18
South Dakota	140	0	5	1	2	4	12
Tennessee	1,094	22	5	1	1	0	28
Texas	3,137	15	4	2	1	1	23
Utah	295	20	11	0	4	1	36
Vermont	116	0	1	1	4	0	7
Virgin Islands	9	1	0	0	-	0	1
Virginia	1,186	3	4	1	4	1	15
Washington	1,013	21	6	0	1	0	28
Washington D.C.	80	2	1	0	0	7	10
West Virginia	389	1	15	2	2	3	23
Wisconsin	938	15	11	1	2	3	32
Wyoming	83	0	1	0	3	1	6

Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports to CMS rather than bids. Totals may not sum due to rounding.

Source: CMS enrollment and population data, 2012.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2012

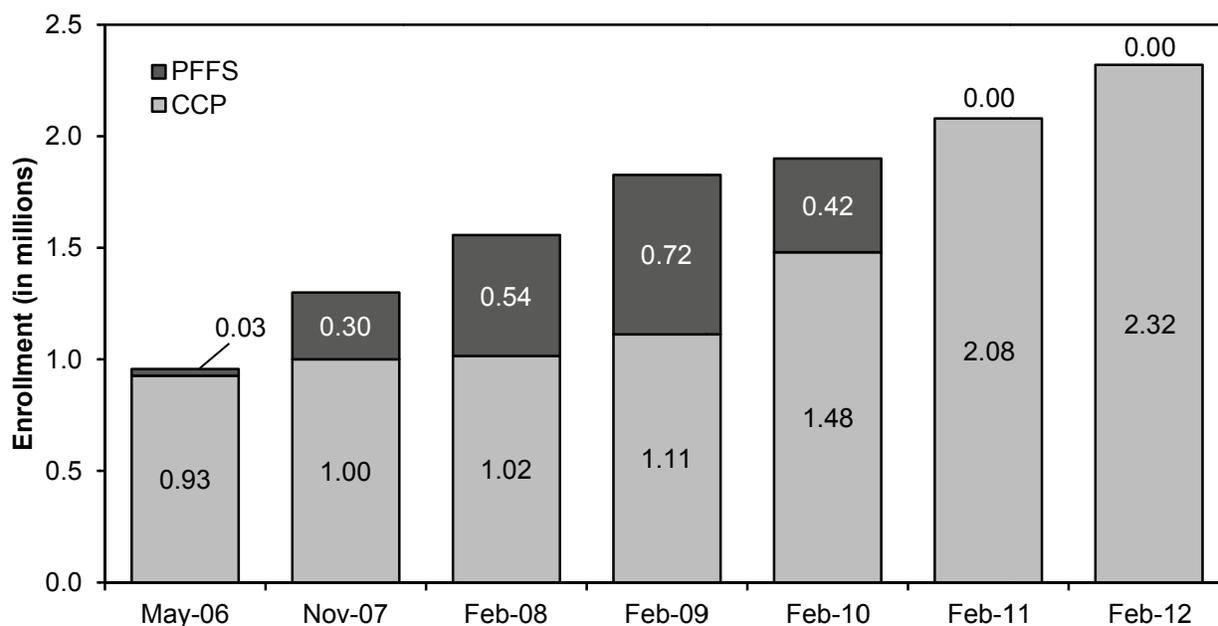
	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	112%	112%	114%	107%	112%
Bids/FFS	98	95	108	100	106
Payments/FFS	107	106	113	105	110

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of plan bid data from CMS, October 2011.

- Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.
- The benchmark is an administratively determined bidding target. Legislation established the formula, being phased in by 2017, for calculating benchmarks in each county, based on percentages (ranging from 95% to 115%) of each county's per-capita Medicare spending.
- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid, plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating and is phased in so that in 2014 it will range from 50 percent to 70 percent. (In 2011, all plan rebates were set at 75 percent.) The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.
- We estimate that MA benchmarks average 112 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, because different types of plans tend to draw enrollment from different types of areas.
- Plans' enrollment-weighted bids average 98 percent of FFS spending. We estimate that HMOs bid an average of 95 percent of FFS spending, while bids from other plan types average at least 100 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid, while other plan types tend to charge more.
- We project that 2012 MA payments will be 107 percent of FFS spending. It is likely this number will decline significantly over the next few years as benchmarks are gradually reduced relative to FFS levels to meet requirements under the Patient Protection and Affordable Care Act of 2010.
- The ratio of payments relative to FFS spending varies by the type of Medicare Advantage plan. HMOs and regional PPO payments are estimated to be 106 percent and 105 percent of FFS, respectively, while payments to PFFS and local PPOs will average 110 percent and 113 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2012

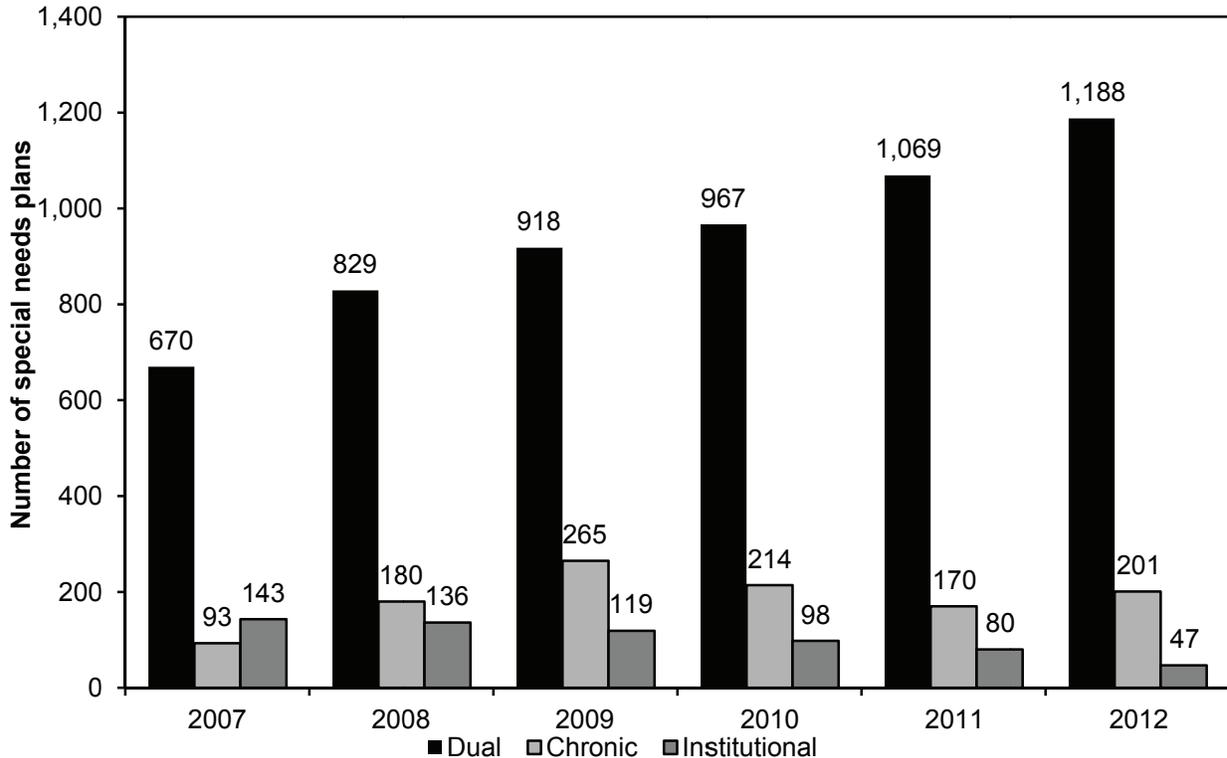


Note: MA (Medicare Advantage), PFFS (private fee-for-service), CCP (coordinated care plan).

Source: CMS enrollment data.

- While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions, rather than to individual beneficiaries.
- Enrollment in employer group plans has more than doubled since 2006, while overall MA enrollment grew by about 82 percent. As of February 2012, about 2.3 million enrollees were in employer group plans, or about 18 percent of all MA enrollees.
- Under a requirement in the Medicare Improvements for Patients and Providers Act of 2008, employer group plans were required to have networks and after 2010 could no longer be PFFS plans.
- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to FFS spending than individual plans, meaning that group plans appear less efficient than individual market MA plans. Employer group plans bid an average of 108 percent of FFS, compared with 96 percent of FFS for individual plans (not shown in chart above).

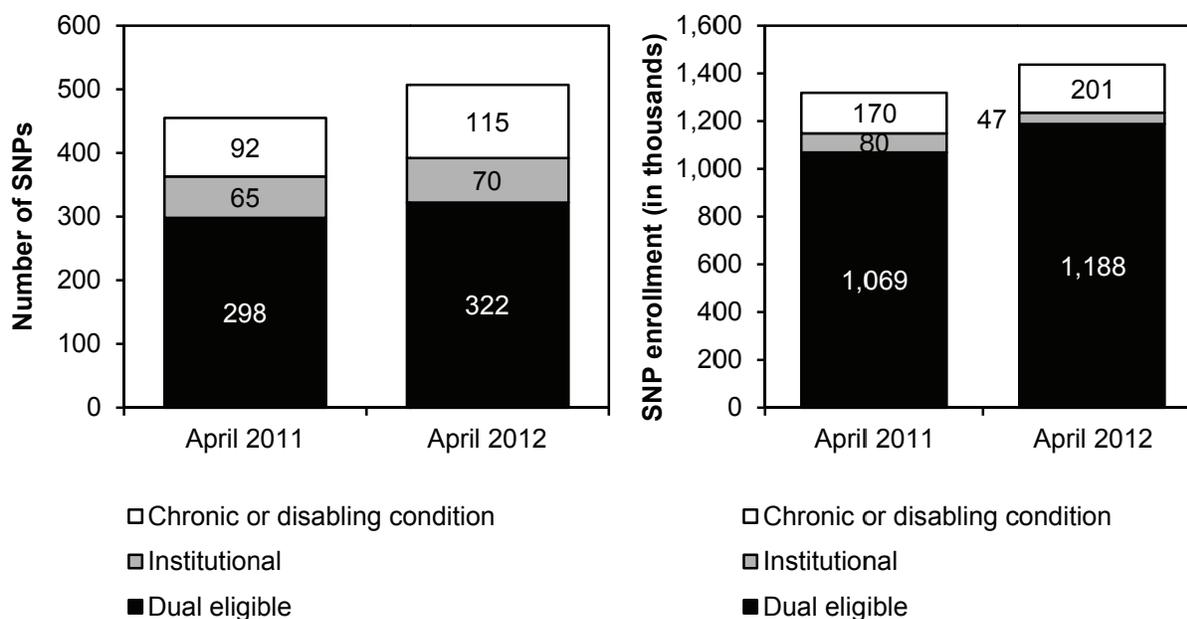
Chart 9-8. Number of special needs plan enrollees, 2007–2012



Source: CMS special needs plans comprehensive reports, May 2007, April 2008, April 2009, April 2010, April 2011, and April 2012.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.
- SNPs were originally authorized for five years. SNP authority was extended, subject to new requirements, by the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Medicare Improvements for Patients and Providers Act of 2008, and the Patient Protection and Affordable Care Act of 2010. Absent congressional action, SNP authority will expire at the end of 2014.
- CMS approves three types of SNPs: dual SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid; chronic SNPs enroll only beneficiaries who have certain chronic or disabling conditions; and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing home certified.
- Enrollment in dual SNPs has grown continuously and is about 1.2 million in 2012.
- Enrollment in chronic SNPs has fluctuated as plan requirements have changed.
- Enrollment in institutional SNPs has declined steadily.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2011 to 2012



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2011 and 2012.

- The number of SNPs increased by 11 percent from April 2011 to April 2012, and the number of SNP enrollees increased by 9 percent.
- In 2012, most SNPs (64 percent) are for dual-eligible beneficiaries, while 23 percent are for beneficiaries with chronic conditions, and 14 percent are for beneficiaries who reside in institutions (or reside in the community, but have a similar level of need).
- Enrollment in SNPs has grown from 0.9 million in May 2007 (not shown) to 1.4 million in April 2012.
- The availability of SNPs has changed slightly and varies by type of special needs population served. In 2012, 78 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 76 percent in 2011), 41 percent live where SNPs serve institutionalized beneficiaries (down from 47 percent), and 45 percent live where SNPs serve beneficiaries with chronic conditions (down from 46 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, defined in the CMS–HCC model, 2008

Conditions (defined by HCCs)	Percent of beneficiaries
Diabetes without complications	13.0%
Breast, prostate, colorectal, and other cancers	7.0
Diabetes with renal or peripheral circulatory manifestation	3.8
CHF	3.0
Diabetes with neurologic or other specified manifestation	2.7
COPD	2.5
Rheumatoid arthritis	2.3
Specified heart arrhythmias	2.3
Vascular disease	2.2
Major depressive, bipolar, and paranoid disorders	2.2
Angina pectoris/old myocardial infarction	1.6
Diabetes with ophthalmologic or unspecified manifestation	1.5
Polyneuropathy	1.3
Lymphatic, head and neck, brain, and other major cancers	1.2
Breast, prostate, colorectal, other cancers; plus diabetes without complication	1.2
Diabetes without complication; plus CHF	1.1
Diabetes with neurologic or other specified manifestation; plus polyneuropathy	0.9
Renal failure	0.9
CHF and specified heart arrhythmias	0.9
Diabetes with renal or peripheral circulatory manifestation; plus polyneuropathy	0.8
Total	52.3

Note: MA (Medicare Advantage), HCC (hierarchical condition category), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease). Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare data files from Acumen LLC.

- CMS uses the CMS–HCC model to risk adjust capitated payments to MA plans. The CMS–HCC uses beneficiaries' conditions that are collected into HCCs to adjust the capitated payments.
- The CMS–HCC includes 70 HCCs, which represent a broad spectrum of conditions. Five of the 70 HCCs represent diabetes categories that vary by severity.
- The five diabetes HCCs are part of 7 of the 20 most common HCC combinations. Other common conditions are congestive heart failure, chronic obstructive pulmonary disease, and various cancers.

Chart 9-11. Distribution of MA plans and enrollment by CMS overall star ratings, April 2012

Plans and enrollment	Star rating: number of stars							Any star rating
	5	4.5	4	3.5	3	2.5	2	
All plan types								
Number of plans	9	46	51	119	144	65	13	447
Enrollment (in thousands)	1,146	1,314	1,267	4,408	3,415	1,080	36	12,665
As percent in rated plans	9%	10%	10%	35%	27%	9%	0.3%	100%
HMOs								
Number of plans	9	38	39	73	87	51	4	301
Enrollment	1,146	1,152	1,076	2,854	1,712	845	29	8,814
As percent of HMO enrollees	13%	13%	12%	32%	19%	10%	0.3%	100%
Local PPOs								
Number of plans	0	8	11	43	40	10	2	114
Enrollment	0	162	190	1,528	684	136	6	2,707
As percent of local PPO enrollees	N/A	6%	7%	56%	25%	5%	0.2%	100%
Regional PPOs								
Number of plans	0	0	0	1	9	2	0	12
Enrollment	0	0	0	21	856	36	0	914
As percent of regional PPO enrollees	N/A	N/A	N/A	2%	94%	4%	0%	100%
PFFS								
Number of plans	0	0	1	2	8	2	0	13
Enrollment	0	0	<1	4	163	63	0	229
As percent of PFFS enrollees	N/A	N/A	0.1%	2%	71%	28%	0%	100%

Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not available). For purposes of this table, a plan is a Medicare Advantage contract, which can consist of several options with different benefit packages that are also referred to as "plans." Numbers may not add to 100 percent due to rounding.

Source: MedPAC analysis of CMS star ratings and enrollment data, 2012.

- The star rating system is a composite measure of clinical processes and outcomes, patient experience measures, and measures of a plan's administrative performance. The overall star rating measures performance on Part C measures and Part D measures.
- The average overall star rating across all plans is 3.36, or 3.57 on an enrollment-weighted basis. There are 115 plans, with 548,000 enrollees, that do not have a star rating because they are too new to be rated or there is insufficient information on which to base a rating.

(Chart continued next page)

Chart 9-11. Distribution of MA plans and enrollment by CMS overall star ratings, April 2012 (continued)

- Under a program-wide demonstration, beginning in 2012, plans with ratings at 3 stars or above receive bonus payments in the form of an increase in their benchmarks. Plan star ratings also determine the level of rebate dollars, though the demonstration does not change the statutory provisions specifying the rebate levels for different star ratings.
- Under the statutory provisions that introduced quality bonus payments, only plans at 4 stars or above would have received bonuses. Under the demonstration, only 10 percent of enrollees are in plans not receiving quality bonuses (2.5- and 2-star plans), whereas under the statutory provisions 71 percent of enrollees would have been in plans not receiving a quality bonus.
- HMOs are the only plan type for which there are 5-star plans. The highest star rating attained by any local PPO is 4.5, whereas the highest rating for a PFFS plan is 4.0 (for one plan), and the highest rating achieved by any regional PPO is 3.5 (one plan).

Under the statutory bonus provisions, no regional PPOs or PFFS plans would have received bonus payments. For local PPOs, 87 percent of enrollees would have been in plans not receiving bonus payments.

- The criteria for determining plan star ratings change from year to year. Plan ratings across years are, therefore, not entirely comparable. Between 2011 and 2012, star rating criteria were changed and a weighting approach was used, with the result that, in 2012, 62 percent of the weight of measures reflects Part C and D clinical quality measures, compared to 49 percent in 2011.

Web links. Medicare Advantage

- Chapter 12 of MedPAC's March 2012 Report to the Congress provides information on Medicare Advantage plans.

http://www.medpac.gov/chapters/Mar12_Ch12.pdf

- More information on the Medicare Advantage program payment system can be found in MedPAC's Medicare Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_MA.pdf

- CMS provides information on Medicare Advantage and other Medicare managed care plans.

<http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html>

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/index.html>

- CMS star ratings for Medicare Advantage plans can be found at

<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

- The official Medicare website provides information on plans available in specific areas and the benefits they offer.

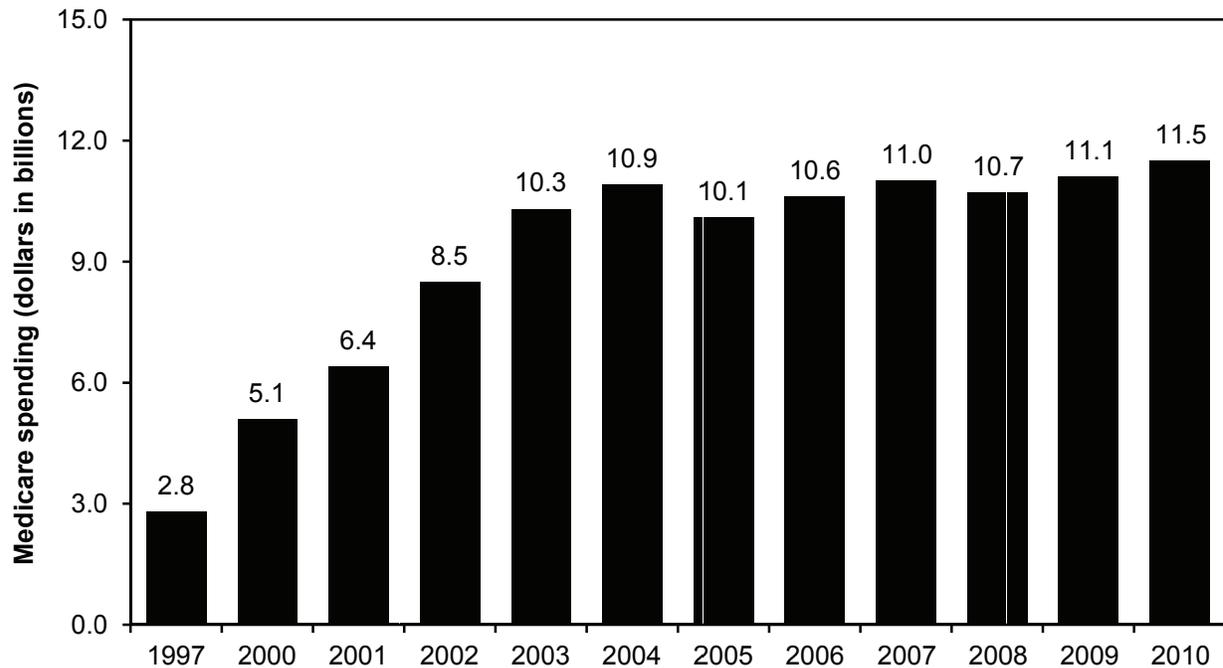
<http://www.medicare.gov/>

SECTION

10

Prescription drugs

Chart 10-1. Medicare spending for Part B drugs administered in physicians' offices or furnished by suppliers



Note: Data include Part B–covered drugs administered in physicians' offices or furnished by suppliers (e.g., certain oral drugs and drugs used with durable medical equipment). Data do not include Part B–covered drugs furnished in hospital outpatient departments or dialysis facilities.

Source: MedPAC analysis of Medicare claims data.

- Spending for Part B drugs administered in physicians' offices or furnished by suppliers totaled about \$11.5 billion in 2010, up 4.3 percent from the 2009 level.
- Medicare spending on Part B drugs increased at an average rate of 25 percent per year from 1997 to 2003. In 2005, the Medicare payment rate changed from one based on the average wholesale price to 106 percent of the average sales price. With the move to the new payment system, spending declined 8 percent in 2005. Since then, spending has increased modestly, growing at an average rate of 2.7 percent per year since 2005.
- In addition to the new payment system, another factor contributing to slower growth in Part B drug spending is reduced use of darbepoetin alfa and epoetin alfa. Annual Part B spending on these products declined by more than \$1 billion between 2005 and 2010 as use of these products decreased in response to changes in Food and Drug Administration labeling and CMS coverage policy. Excluding these two products, Part B drug spending has grown at an average rate of 5.4 per year since 2005.
- This total does not include drugs provided through outpatient departments of hospitals or to patients with end-stage renal disease in dialysis facilities. MedPAC estimates that payments (including cost sharing) for separately billed drugs provided in hospital outpatient departments equaled about \$4.1 billion in 2010. We estimate that freestanding and hospital-based dialysis facilities billed Medicare an additional \$3.0 billion for drugs in 2010.

Chart 10-2. Top 10 Part B drugs administered in physicians' offices or furnished by suppliers, by share of expenditures, 2010

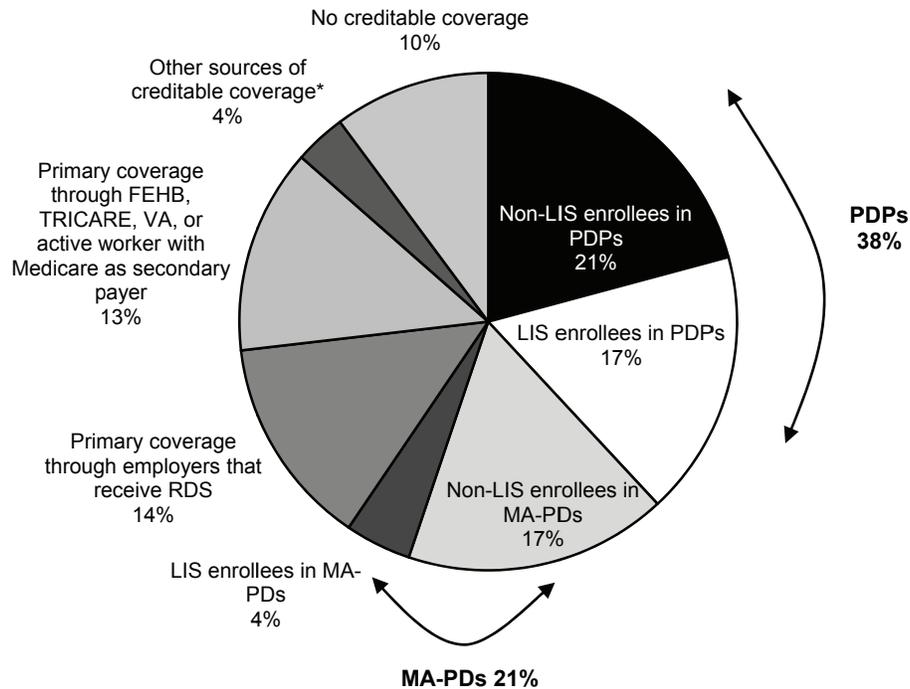
Drug name	Clinical indications	Allowed Charges (in millions)	Competition	Percent of spending	Rank in 2009
Ranibizumab	Age-related macular degeneration	\$1,119	Sole source	9.7%	2
Rituximab	Lymphoma, leukemia, rheumatoid arthritis	\$849	Sole source	7.4	1
Bevacizumab	Cancer, age-related macular degeneration	\$766	Sole source	6.6	3
Infliximab	Rheumatoid arthritis, Crohn's disease	\$647	Sole source	5.6	4
Pegfilgrastim	Cancer	\$553	Sole source	4.8	5
Darbepoetin alfa	Anemia	\$374	Sole source	3.2	6
Epoetin alfa	Anemia	\$327	Multisource biologic	2.8	7
Pemetrexed	Lung cancer	\$276	Sole source	2.4	not listed
Docetaxel	Cancer	\$269	Sole source*	2.3	9
Tacrolimus	Prevent organ transplant rejection	\$259	Multisource	2.2	10

Note: Data do not include Part B drugs furnished in hospital outpatient departments or dialysis facilities. Allowed charges include Medicare program payments and beneficiary cost-sharing. Clinical indications may include on- and off-label use. *Docetaxel was sole source in 2009, but generic versions have since become available.

Source: MedPAC analysis of Medicare claims data from CMS and information on drug and biologic approval information from the Food and Drug Administration website (<http://www.fda.gov>).

- Medicare covers approximately 600 outpatient drugs under Part B, but spending is very concentrated. The top 10 drugs account for about 47 percent of all Part B drug spending.
- Ranibizumab, a biologic for age-related macular degeneration, was the Part B drug with the greatest Medicare expenditures in 2010, exceeding \$1.1 billion.
- The seven highest expenditure products are biologics.
- Treatment for cancer dominates the list (7 of the top 10 drugs treat cancer or the side effects associated with chemotherapy) because most cancer drugs must be administered by physicians, a requirement for coverage of most Part B drugs.
- Data reflect Part B drugs administered in physicians' offices or furnished by suppliers.

Chart 10-3. In 2010, about 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage



Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program), VA (Department of Veterans Affairs). TRICARE is the health program for military retirees and their dependents.
*Creditable coverage means drug benefits whose value is equal to or greater than that of the basic Part D benefit.

Source: CMS Management Information Integrated Repository, February 16, 2010; Office of Personnel Management; Department of Defense; Department of Veterans Affairs; CMS Coordination of Benefits Database; CMS Creditable Coverage Database.

- As of February 2010, CMS estimated that 34 million of the 46 million Medicare beneficiaries (73 percent) were either signed up for Part D plans or had prescription drug coverage through employer-sponsored plans under Medicare’s RDS. (If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal to or greater in value than that of Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual’s drug costs that fall within a specified range of spending.)
- About 10 million beneficiaries (nearly 22 percent) receive Part D’s LIS. Of these individuals, 6.4 million are dually eligible to receive Medicare and all Medicaid benefits offered in their state. Another 3.5 million qualified for extra help either because they receive benefits through the Medicare Savings Program or Supplemental Security Income Program or because they applied directly to the Social Security Administration. Among all LIS beneficiaries, about 8 million (17 percent of all Medicare beneficiaries) are enrolled in stand-alone PDPs and 2 million (4 percent) are in MA–PD plans.

(Chart continued next page)

Chart 10-3. In 2010, about 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage (continued)

- Other enrollees in stand-alone PDPs numbered 9.7 million, or 21 percent of all Medicare beneficiaries. Another 7.9 million enrollees (17 percent) are in MA–PD plans or other private Medicare health plans. Individuals whose employers receive Medicare’s RDS numbered 6.4 million, or 14 percent. Those groups of beneficiaries directly affect Medicare program spending.
- Other Medicare beneficiaries have creditable drug coverage, but that coverage does not affect Medicare program spending. For example, 6.2 million beneficiaries (13 percent) receive drug coverage through the FEHB, TRICARE, VA, or current employers because the individual is still an active worker. CMS estimates that another 1.6 million individuals have other sources of creditable coverage.
- An estimated 4.7 million beneficiaries (10 percent) have no creditable drug coverage.

Chart 10-4. Parameters of the defined standard benefit increase over time

	2006	2009	2010	2011	2012
Deductible	\$250.00	\$295.00	\$310.00	\$310.00	\$320.00
Initial coverage limit	2,250.00	2,700.00	2,830.00	2,840.00	2,930.00
Annual out-of-pocket threshold	3,600.00	4,350.00	4,550.00	4,550.00	4,700.00
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,153.75	6,440.00	6,447.50	6,657.50
Maximum amount of cost sharing in the coverage gap	2,850.00	3,453.75	3,610.00	3,607.50	3,727.50
Minimum cost sharing above the annual out-of-pocket threshold					
Copay for generic/preferred multisource drug	2.00	2.40	2.50	2.50	2.60
Copay for other prescription drugs	5.00	6.00	6.30	6.30	6.50

Note: Under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending (75 percent paid by the plan) until total covered drug spending reaches the initial coverage limit (ICL). Before 2011, enrollees exceeding the ICL were responsible for paying 100 percent of covered drug spending up to the annual out-of-pocket threshold. Beginning in 2011, enrollees face reduced cost sharing in the coverage gap. The amount for 2012 (\$6,657.50) is for an individual with no other sources of supplemental coverage filling only brand-name drugs during the coverage gap. Cost sharing paid by most sources of supplemental coverage does not count toward this threshold. The enrollee pays nominal cost sharing above the limit.

Source: CMS, Office of the Actuary.

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 specified a defined standard benefit structure. In 2012, it has a \$320 deductible, 25 percent coinsurance on covered drugs until the enrollee reaches \$2,930 in total covered drug spending, and then a coverage gap until annual out-of-pocket spending reaches the annual threshold. Before 2011, enrollees were responsible for paying the full discounted price of covered drugs filled during the coverage gap. Because of changes made by the Patient Protection and Affordable Care Act of 2010, enrollees face reduced cost sharing for drugs filled in the coverage gap. In 2012, the cost sharing for drugs filled during the gap phase is 50 percent for brand-name drugs and 86 percent for generic drugs. Enrollees with drug spending that exceeds the annual threshold would pay the greater of \$2.60 to \$6.50 per prescription or 5 percent coinsurance.
- The parameters of this defined standard benefit structure increase over time at the same rate as the annual increase in average total drug expenses of Medicare beneficiaries.
- Within certain limits, sponsoring organizations may offer Part D plans that have the same actuarial value as the defined standard benefit, but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance. Or a plan may have no deductible, but use cost-sharing requirements that are equivalent to a rate higher than 25 percent. Both defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are known as “basic benefits.”
- Once a sponsoring organization offers one plan with basic benefits within a prescription drug plan region, it may also offer a plan with enhanced benefits—basic and supplemental coverage combined.

Chart 10-5. Characteristics of Medicare PDPs

	2011				2012			
	Plans		Enrollees as of February 2011		Plans		Enrollees as of February 2012	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,109	100%	17.0	100%	1,041	100%	17.5	100%
Type of organization								
National ^a	851	77	13.9	82	838	80	14.9	85
Other	258	23	3.0	18	203	20	2.6	15
Type of benefit								
Defined standard	133	12	1.3	8	95	9	1.0	5
Actuarially equivalent ^b	474	43	12.6	74	446	43	13.2	75
Enhanced	502	45	3.0	18	500	48	3.3	19
Type of deductible								
Zero	464	42	7.3	43	488	47	7.3	42
Reduced	197	18	2.1	13	108	10	1.8	11
Defined standard ^c	448	40	7.6	45	445	43	8.3	48
Drugs covered in the gap								
Some generics but no brand-name drugs	259	23	2.2	13	197	19	0.8	4
Some generics and some brand-name drugs	106	10	0.3	2	73	7	0.3	2
None	744	67	14.4	85	771	74	16.4	94

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Excluded plans have 2 million enrollees in 2012 and had 1.6 million in 2011. Sums may not add to totals due to rounding.

^a Reflects total numbers of plans for organizations with at least 1 PDP in each of the 34 PDP regions.

^b Includes "actuarially equivalent standard" and "basic alternative" benefits.

^c \$310 in 2011 and \$320 in 2012.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

- Part D drew about 6 percent fewer stand-alone PDPs into the field for 2012 than in 2011. Plan sponsors are offering 1,041 PDPs in 2012 compared with 1,109 in 2011.
- In 2012, 80 percent of all PDPs are offered by sponsoring organizations that have at least 1 PDP in each of the 34 PDP regions. Plans offered by those national sponsors account for 85 percent of all PDP enrollment.
- Sponsors are offering about the same number of PDPs with enhanced benefits (basic plus supplemental coverage) for 2012 and fewer PDPs with actuarially equivalent benefits—having the same average value as the defined standard benefit, but with alternative benefit designs. Most enrollees (75 percent) are in actuarially equivalent plans.
- A smaller proportion of PDPs include some benefits in the coverage gap for 2012 than in 2011. About 27 percent of all plans with some gap coverage offer generics and brand-name drugs, compared with about a third in 2011.
- In 2012, 94 percent of PDP enrollees are in plans that offer no additional benefits in the coverage gap. However, because of the changes made by the Patient Protection and Affordable Care Act of 2010, beginning in 2011, beneficiaries no longer face 100 percent coinsurance in the coverage gap (see Chart 10-4). In addition, many PDP enrollees receive Part D's low-income subsidy, which effectively eliminates the coverage gap.

Chart 10-6. Characteristics of MA-PDs

	2011				2012			
	Plans		Enrollees as of February 2011		Plans		Enrollees as of February 2012	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Totals	1,506	100%	8.6	100%	1,541	100%	8.5	100%
Type of organization								
Local HMO	909	60	5.7	66	951	62	5.9	69
Local PPO	421	28	1.7	20	430	28	1.5	18
PFFS	137	9	0.5	5	125	8	0.4	5
Regional PPO	39	3	0.7	8	35	2	0.7	8
Type of benefit								
Defined standard	42	3	0.1	1	37	2	0.1	1
Actuarially equivalent*	108	7	0.6	7	86	6	0.5	6
Enhanced	1,356	90	7.9	92	1,418	92	7.9	94
Type of deductible								
Zero	1,320	88	7.8	91	1,372	89	7.5	88
Reduced	110	7	0.5	6	98	6	0.8	9
Defined standard**	76	5	0.2	3	71	5	0.2	2
Drugs covered in the gap								
Some generics but no brand-name drugs	441	29	3.0	36	373	24	2.1	25
Some generics and some brand-name drugs	350	23	1.6	19	397	26	2.3	27
None	715	47	3.9	46	771	50	4.0	48

Note: MA-PD (Medicare Advantage-Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA-PD plans and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Sums may not add to totals due to rounding. In previous years, we have treated different segments of an MA-PD as separate plans for the purpose of reporting the number of plans available. The figures shown above no longer distinguish between different segments of a plan.

*Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

**\$310 in 2011 and \$320 in 2012.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

- There are slightly more MA-PD plans in 2012 than in 2011. Sponsors are offering 1,541 MA-PD plans compared with 1,506 the year before (about 2 percent more). HMOs remain the dominant kind of MA-PD plans, making up 62 percent of all (unweighted) offerings in 2012. The number of PFFS plans continues to decline, from 137 in 2011 to 125 in 2012. The number of drug plans offered by both local and regional preferred provider organizations decreased slightly between 2011 and 2012.
- A larger share of MA-PD plans than stand-alone prescription drug plans (PDPs) offer enhanced benefits (compare Chart 10-6 with Chart 10-5). In 2012, 48 percent of all PDPs had enhanced benefits compared with 92 percent of MA-PD plans. In 2012, enhanced MA-PD plans attracted 94 percent of total MA-PD enrollment.
- Most MA-PD plans have no deductible: 89 percent of MA-PD offerings in 2012 and 88 percent in 2011. MA-PD plans with no deductible attracted about 88 percent of total MA-PD enrollment in 2012.
- MA-PD plans are more likely than PDPs to provide some additional benefits in the coverage gap. In 2012, 50 percent of MA-PD plans included some gap coverage—24 percent with some generics, but no brand-name drug coverage and 26 percent with some generics and some brand-name drug coverage. Those plans account for 52 percent of MA-PD enrollment.

Chart 10-7. Average Part D premiums

	2011 enrollment (in millions)	Average monthly 2011 premium weighted by 2011 enrollment	2012 enrollment (in millions)	Average monthly 2012 premium weighted by 2012 enrollment	Dollar change	Percentage change in weighted average premium
PDPs						
Basic coverage	13.9	\$33	14.1	\$33	\$0	0 %
Enhanced coverage	3.0	63	3.3	58	-4.5	-7
Any coverage	17.0	38	17.5	38	-0.6	-1
MA-PDs, including SNPs*						
Basic coverage	1.1	27	1.3	27	-0.1	-1
Enhanced coverage	7.5	12	8.0	12	0.1	1
Any coverage	8.6	14	9.3	14	0.3	2
All plans						
Basic coverage	15.0	33	15.5	33	-0.1	0
Enhanced coverage	10.6	26	11.3	26	-1.0	-4
Any coverage	25.5	30	26.8	30	-0.5	-2

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), SNPs (special needs plans). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA-PD plans and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans.

*Reflects the portion of Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA-PD premiums reflect rebate dollars (between 67 percent and 73 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services in 2012) that were used to offset Part D premium costs. Lower average premiums for enhanced MA-PD plans reflect a different mix of sponsoring organizations and counties of operation than MA-PD plans with basic coverage.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

- The average premium paid by Part D enrollees remained stable at around \$30 per month in 2012.
- The average premiums for beneficiaries enrolled in PDP remained flat in 2012 at \$38 per month, a decrease of less than \$1.
- MA-PD plans can lower the part of their monthly premium attributable to Part D using rebate dollars—a portion (between 67 percent and 73 percent in 2012) of the difference between the plan's payment benchmark and its bid for providing Part A and Part B services. MA-PD plans may also enhance their Part D benefit with rebate dollars. Many MA-PD plans use rebate dollars in these ways, resulting in more enhanced offerings and lower average premiums compared with PDPs.
- The portion of Medicare Advantage premiums attributable to prescription drug benefits remained flat (increase of less than \$1) in 2012, with the average MA-PD enrollee paying \$14 per month.

Chart 10-8. Number of PDPs qualifying as premium-free to LIS enrollees remained stable in 2012

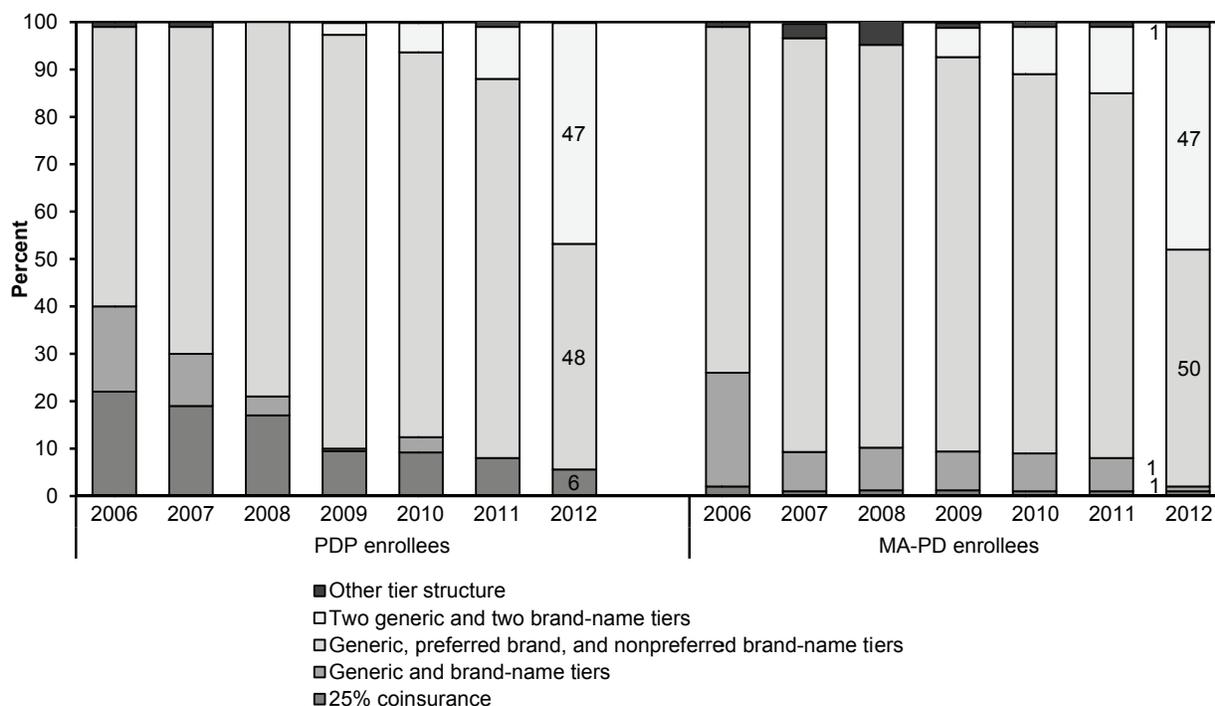
PDP region	State(s)	Number of PDPs			Number of PDPs that have zero premium for LIS enrollees		
		2011	2012	Difference	2011	2012	Difference
1	ME, NH	30	28	-2	7	8	1
2	CT, MA, RI, VT	34	30	-4	12	10	-2
3	NY	33	29	-4	11	12	1
4	NJ	33	30	-3	6	9	3
5	DC, DE, MD	33	31	-2	12	13	1
6	PA, WV	38	36	-2	12	12	0
7	VA	32	30	-2	10	10	0
8	NC	33	30	-3	11	9	-2
9	SC	34	32	-2	15	12	-3
10	GA	32	30	-2	14	12	-2
11	FL	32	33	1	4	3	-1
12	AL, TN	34	32	-2	11	12	1
13	MI	35	34	-1	12	12	0
14	OH	34	33	-1	8	8	0
15	IN, KY	32	31	-1	14	13	-1
16	WI	32	29	-3	10	10	0
17	IL	35	33	-2	10	10	0
18	MO	32	30	-2	5	8	3
19	AR	34	30	-4	17	15	-2
20	MS	32	30	-2	14	12	-2
21	LA	32	30	-2	10	12	2
22	TX	33	33	0	12	13	1
23	OK	33	30	-3	10	9	-1
24	KS	33	31	-2	12	10	-2
25	IA, MN, MT, ND, NE, SD, WY	33	33	0	10	9	-1
26	NM	32	30	-2	8	6	-2
27	CO	31	28	-3	7	5	-2
28	AZ	30	30	0	9	10	1
29	NV	31	29	-2	4	2	-2
30	OR, WA	32	30	-2	8	9	1
31	ID, UT	35	33	-2	11	12	1
32	CA	33	33	0	5	6	1
33	HI	28	25	-3	6	10	4
34	AK	29	25	-4	5	4	-1
	Total	1,109	1,041	-68	332	327	-5

Note: PDP (prescription drug plan), LIS (low-income subsidy).

Source: MedPAC based on 2012 PDP landscape file provided by CMS.

- The number of stand-alone PDPs decreased by 6 percent around the country, from 1,109 in 2011 to 1,041 in 2012. The median number of plans offered in each region in 2012 is 30 compared with 33 in 2011.
- Hawaii and Alaska had the fewest stand-alone PDPs with 25; the Pennsylvania–West Virginia region had the most with 36.
- In 2012, enrollees who receive Part D's LIS have about the same number of options for PDPs in which they pay no premium. In 2012, 327 PDPs qualified to be premium-free to those enrollees, compared with 332 in 2011.
- Each region has at least two PDPs available to LIS enrollees at no premium; most regions have substantially more zero premium plans available.

Chart 10-9. In 2012, most Part D enrollees are in plans that charge higher copayments for nonpreferred brand-name drugs

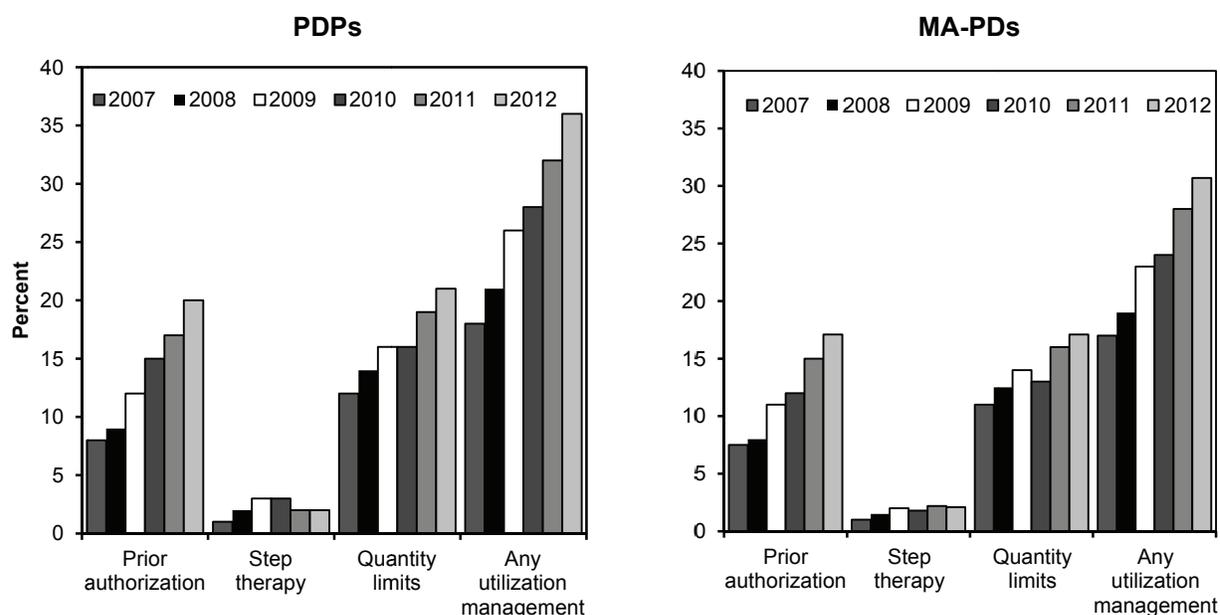


Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PD plans exclude demonstration programs, special needs plans, and 1876 cost plans. Sums may not add to totals due to rounding.

Source: MedPAC-sponsored analysis by NORC/Georgetown University/Social and Scientific Systems analysis of formularies submitted to CMS.

- In 2012, 48 percent of PDP enrollees are in plans that distinguish between preferred and nonpreferred brand-name drugs; another 47 percent are in plans with two generic and two brand-name tiers. In 2006, only 59 percent of PDP enrollees were in plans with such distinctions. Nearly all (97 percent) MA–PD enrollees are in such plans in 2012, up from 73 percent in 2006.
- For enrollees in PDPs that distinguish between preferred and nonpreferred brand-name drugs, the median copay in 2012 is \$41 for a preferred brand and \$93 for a nonpreferred brand. The median copay for generic drugs is \$5. For MA–PD enrollees, in 2012, the median copay is \$42 for a preferred brand, \$84 for a nonpreferred brand, and \$6 for a generic drug.
- Most plans, except those that use the defined standard benefit’s 25 percent coinsurance for all drugs, also use a specialty tier for drugs that have a negotiated price of \$600 per month or more. In 2012, median cost sharing for a specialty tier drug is 30 percent among PDPs and 33 percent among MA–PD plans. Enrollees may not appeal cost sharing for drugs in specialty tiers.

Chart 10-10. In 2012, use of utilization management tools continues to increase for both PDPs and MA-PDs



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA-PD plans exclude demonstration programs, special needs plans, and 1876 cost plans. Values reflect the percent of listed chemical entities that are subject to utilization management, weighted by plan enrollment. Prior authorization means that the enrollee must get preapproval from the plan before coverage. Step therapy refers to a requirement that the enrollee try specified drugs first before moving to other drugs. Quantity limits mean that plans limit the number of doses of a drug available to the enrollee in a given time period.

Source: MedPAC-sponsored analysis by NORC/Georgetown University/Social and Scientific Systems analysis of formularies submitted to CMS.

- The number of drugs listed on a plan's formulary does not necessarily represent beneficiary access to medications. Plans' processes for nonformulary exceptions, prior authorization (preapproval from plan before coverage), quantity limits (plans limit the number of doses of a particular drug covered in a given time period), and step therapy requirements (enrollees must try specified drugs before moving to other drugs) can affect access to certain drugs. For example, unlisted drugs may be covered through the nonformulary exceptions process, which may be relatively easy for some plans and more burdensome for others. Alternatively, on-formulary drugs may not be covered in cases in which a plan does not approve a prior authorization request. Also, a formulary's size can be deceptively large if it includes drugs that are no longer used in common practice.
- In 2012, the average enrollee in a stand-alone prescription drug plan faces some form of utilization management for 36 percent of drugs listed on a plan's formulary, compared with 31 percent for the average MA-PD plan enrollee. Part D plans typically use quantity limits or prior authorization to manage enrollees' prescription drug use.

Chart 10-11. Characteristics of Part D enrollees, 2010

	All Medicare	Part D	Plan type		Subsidy status	
			PDP	MA–PD	LIS	Non-LIS
Beneficiaries ^a (in millions)	49.9	29.7	18.9	10.6	11.3	18.4
Percent of all Medicare	100%	60%	38%	21%	23%	37%
Gender						
Male	45%	41%	40%	43%	39%	43%
Female	55	59	60	57	61	57
Race/ethnicity						
White, non-Hispanic	77	74	76	71	58	84
African American, non-Hispanic	10	11	11	11	20	6
Hispanic	8	10	8	14	15	7
Asian	3	3	3	3	5	2
Other	2	2	2	1	2	1
Age (years)						
<65	22	23	27	17	42	12
65–69	24	22	20	26	14	27
70–74	18	18	17	20	13	21
75–79	14	14	13	16	11	16
80+	22	22	23	21	20	24
Urbanicity^d						
Metropolitan	78	79	74	88	77	80
Micropolitan	12	12	15	7	13	11
Rural	8	9	11	4	10	8
Average risk score^c						
	1.062	1.117	1.137	1.083	1.217	1.055
Percent relative to all Part D		100%	102%	97%	109%	94%

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Totals may not sum to 100 percent due to rounding.

^a Figures for Medicare and Part D include all beneficiaries with at least one month of enrollment in the respective program. A beneficiary is classified as LIS if that individual received Part D's LIS at some point during the year. For individuals who switch plan types during the year, classification into plan types is based on a greater number of months of enrollment. About 200,000 enrollees could not be classified into a plan type due to missing data.

^b Urbanicity based on the Office of Management and Budget's core-based statistical area. A metropolitan area contains a core urban area of 50,000 or more population, and a micropolitan area contains an urban core of at least 10,000 (but less than 50,000) population. About 1 percent of Medicare beneficiaries were excluded due to an unidentifiable core-based statistical area designation.

^c Part D risk scores are calculated by CMS using the prescription drug hierarchical condition category model developed before 2006. Risk scores shown here are not adjusted for LIS or institutionalized status (multipliers).

Source: MedPAC analysis of Medicare Part D denominator and Risk Adjustment System files from CMS.

- In 2010, 29.7 million Medicare beneficiaries (60 percent) enrolled in Part D at some point in the year. Most of them (18.9 million) were in stand-alone PDPs, with 10.6 million in MA–PD plans. A little over 11 million enrollees received Part D's LIS.

(Chart continued next page)

Chart 10-11. Characteristics of Part D enrollees, 2010 (continued)

- Compared with the overall Medicare population, Part D enrollees are more likely to be female and non-White. MA–PD enrollees are less likely to be disabled beneficiaries under age 65 and more likely to be Hispanic compared with PDP enrollees; LIS enrollees are more likely to be female, non-White, and disabled beneficiaries under age 65 compared with non-LIS enrollees.
- Patterns of enrollment by urbanicity for Part D enrollees were similar to the overall Medicare population with 79 percent in metropolitan areas, 12 percent in micropolitan areas, and the remaining 9 percent in rural areas.
- The average risk score for PDP enrollees is higher (1.137) than the average for all Part D enrollees (1.117), while the average risk score for MA–PD enrollees is lower (1.083).

Chart 10-12. Part D enrollment trends, 2006–2010

	2006	2007	2008	2009	2010
Part D enrollment, in millions*					
Total	24.5	26.1	27.5	28.7	29.7
By plan type					
PDP	17.7	18.3	18.6	18.7	18.9
MA–PD	6.8	7.8	8.9	10.0	10.6
By subsidy status					
LIS	10.2	10.4	10.7	10.9	11.3
Non-LIS	14.3	15.7	16.9	17.8	18.4
By race/ethnicity					
White, non-Hispanic	17.2	19.4	20.5	21.4	22.0
African American, non-Hispanic	2.6	2.9	3.1	3.2	3.3
Hispanic	2.2	2.5	2.7	2.8	3.0
Other	2.5	1.3	1.3	1.3	1.4
By age (years)					
<65	5.6	6.1	6.4	6.6	6.9
65–69	5.0	5.4	5.9	6.3	6.6
70–79	8.3	8.7	9.0	9.3	9.6
80+	5.6	6.0	6.3	6.4	6.6
Enrollment growth, in percent					
Total	—	7%	5%	4%	4%
By plan type					
PDP	—	4	2	<1	1
MA–PD	—	14	14	12	6
By subsidy status					
LIS	—	2	2	2	4
Non-LIS	—	10	8	6	3
By race/ethnicity					
White, non-Hispanic	—	13	5	4	3
African American, non-Hispanic	—	13	5	4	4
Hispanic	—	14	6	6	6
Other	—	–49	6	<1	6
By age (years)					
<65	—	8	6	4	4
65–69	—	8	8	7	5
70–79	—	5	4	4	3
80+	—	7	4	3	2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy).

*Figures include all beneficiaries with at least one month of enrollment. A beneficiary is classified as LIS if that individual received Part D's LIS at some point during the year. If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified into the type of plan with a greater number of months of enrollment. About 200,000 enrollees could not be classified into a plan type due to missing data. Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D denominator file from CMS.

- Between 2006 and 2010, MA–PD plan enrollment grew faster (by more than 10 percent per year between 2006 and 2009, and by 6 percent between 2009 and 2010) compared with growth rates of less than 5 percent per year for prescription drug plans. The number of enrollees receiving the LIS remained relatively flat between 2006 and 2009, while the number of non-LIS enrollees grew by 10 percent in 2007, 8 percent in 2008, and 6 percent in 2009. The growth in the number of LIS and non-LIS enrollees was 3 percent and 4 percent, respectively, between 2009 and 2010.

Chart 10-13. Part D enrollment by region, 2010

PDP region	State(s)	Percent of Medicare enrollment		Percent of Part D enrollment			
		Part D	RDS	Plan type		Subsidy status	
				PDP	MA–PD	LIS	Non-LIS
1	ME, NH	56%	12%	85%	15%	49%	51%
2	CT, MA, RI, VT	59	18	69	31	43	57
3	NY	60	18	55	45	46	54
4	NJ	53	22	81	19	35	65
5	DE, DC, MD	47	17	86	14	41	59
6	PA, WV	63	13	56	44	33	67
7	VA	53	10	78	22	37	63
8	NC	60	16	75	25	43	57
9	SC	55	16	77	23	45	55
10	GA	61	10	69	31	43	57
11	FL	61	13	53	47	35	65
12	AL, TN	61	13	65	35	47	53
13	MI	48	31	73	27	40	60
14	OH	55	23	63	37	36	64
15	IN, KY	60	14	80	20	39	61
16	WI	55	15	63	37	33	67
17	IL	56	19	87	13	38	62
18	MO	63	11	69	31	35	65
19	AR	61	9	80	20	45	55
20	MS	65	6	88	12	54	46
21	LA	62	13	65	35	49	51
22	TX	57	15	69	31	45	55
23	OK	60	8	79	21	38	62
24	KS	63	7	85	15	29	71
25	IA, MN, MT, NE, ND, SD, WY	66	9	73	27	27	73
26	NM	62	8	62	38	39	61
27	CO	59	13	49	51	29	71
28	AZ	61	12	45	55	32	68
29	NV	56	13	48	52	29	71
30	OR, WA	59	11	59	41	31	69
31	ID, UT	58	10	56	44	28	72
32	CA	70	9	51	49	39	61
33	HI	66	4	44	56	29	71
34	AK	39	26	99	1	62	38
	Mean	60	14	64	36	38	62
	Minimum	39	4	44	1	27	38
	Maximum	70	31	99	56	62	73

Note: PDP (prescription drug plan), RDS (retiree drug subsidy), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Definition of regions based on PDP regions used in Part D.

Source: MedPAC analysis of Part D enrollment data from CMS.

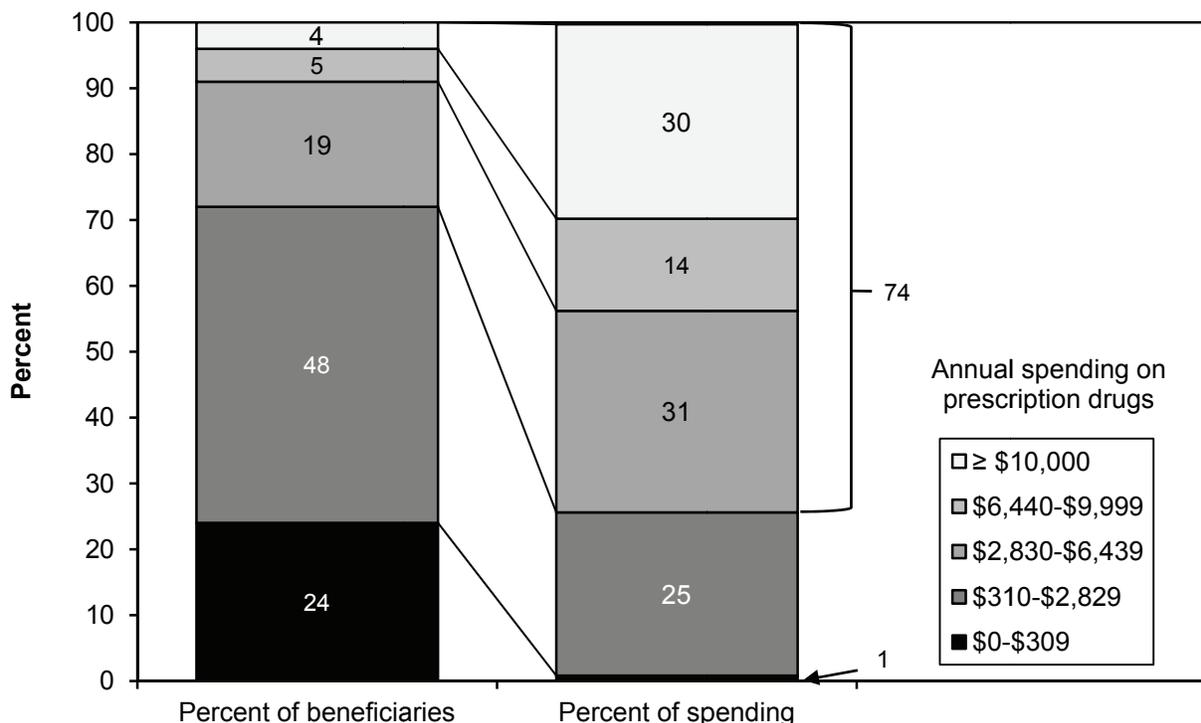
- Among Part D regions, in 2010, between 39 percent and 70 percent of all Medicare beneficiaries enrolled in Part D. Beneficiaries were more likely to enroll in Part D in regions where a low take-up rate for the RDS was observed. For example, in Region 32 (California) and Region 33 (Hawaii), the shares of Medicare beneficiaries enrolled in Part D were 70 percent and 66 percent, respectively. In these two regions, fewer than 10 percent of beneficiaries enrolled in employer-sponsored plans that received the RDS.
- A wide variation was seen in the shares of Part D enrollees who enrolled in PDPs and MA–PD plans across PDP regions. The pattern of MA–PD enrollment is generally consistent with enrollment in Medicare Advantage plans.

(Chart continued next page)

Chart 10-13. Part D enrollment by region, 2010 (continued)

- The share of Part D enrollees receiving the LIS ranged from 27 percent in Region 25 (Iowa, Minnesota, Montana, North Dakota, Nebraska, South Dakota, and Wyoming) to 62 percent in Region 34 (Alaska). In 26 of the 34 PDP regions, LIS enrollees account for 30 percent to 50 percent of enrollment. In two regions, Region 20 (Mississippi) and Region 34 (Alaska), LIS enrollees account for more than half of Part D enrollment.

Chart 10-14. The majority of Part D spending is incurred by fewer than half of all Part D enrollees, 2010



Note: Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- Medicare Part D spending is concentrated among a subset of beneficiaries. In 2010, 28 percent of Part D enrollees had annual spending of \$2,830 or more, at which point enrollees were responsible for 100 percent of the cost of the drug until their spending reached \$6,440 under the defined standard benefit. These beneficiaries accounted for 74 percent of total Part D spending.
- The costliest 9 percent of beneficiaries, those with drug spending above the catastrophic threshold under the defined standard benefit, accounted for 44 percent of total Part D spending. Slightly over three-quarters of beneficiaries with the highest spending receive Part D's low-income subsidy (see Chart 10-15). Spending on prescription drugs is less concentrated than Medicare Part A and Part B spending. In 2010, the costliest 5 percent of beneficiaries accounted for 38 percent of annual Medicare fee-for-service (FFS) spending, and the costliest quartile accounted for 81 percent of Medicare FFS spending

Chart 10-15. Characteristics of Part D enrollees, by spending levels, 2010

	Annual drug spending		
	<\$2,830	\$2,830–\$6,440	>\$6,440
Sex			
Male	42%	38%	39%
Female	58	62	61
Race/ethnicity			
White, non-Hispanic	74	75	71
African American, non-Hispanic	11	11	14
Hispanic	10	9	10
Other	5	5	5
Age (years)			
<65	21	22	44
65–69	24	19	14
70–74	19	18	13
75–80	14	15	11
80+	21	26	19
LIS status*			
LIS	31	46	77
Non-LIS	69	54	23
Plan type**			
PDP	61	70	80
MA–PD	39	30	20

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). A small number of beneficiaries were excluded from the analysis because of missing data. Totals may not sum to 100 percent due to rounding.

*A beneficiary is assigned LIS status if that individual received Part D's LIS at some point during the year.

**If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified in the type of plan with a greater number of months of enrollment.

Source: MedPAC analysis of Medicare Part D prescription drug events data and Part D denominator file from CMS.

- In 2010, beneficiaries with annual drug spending of more than \$2,830 were more likely to be female than beneficiaries with annual spending below \$2,830 (62 percent and 61 percent compared with 58 percent).
- Beneficiaries with annual spending greater than \$6,440 are more likely to be disabled beneficiaries under age 65 and receive the LIS compared with those with annual spending below \$2,830.
- Most beneficiaries with spending greater than \$6,440 are enrolled in stand-alone PDPs (80 percent) compared with MA–PD plans (20 percent). On the other hand, beneficiaries with annual spending below \$2,830 are more likely to be in MA–PDs compared with those with higher annual spending (39 percent compared with 20 percent). This finding reflects the fact that most LIS enrollees are more costly on average and are in PDPs.

Chart 10-16. Part D spending and utilization per enrollee, 2010

	Part D	Plan type		LIS status	
		PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions)	\$77.7	\$56.7	\$20.9	\$43.3	\$34.4
Total number of prescriptions ^a (millions)	1,406	944	462	629	777
Average spending per prescription	\$55	\$60	\$45	\$69	\$44
Per enrollee per month					
Total spending	\$231	\$265	\$172	\$348	\$163
Out-of-pocket spending ^b	40	41	37	8	59
Plan liability ^c	138	154	111	197	103
Low-income cost sharing subsidy	53	70	23	142	N/A
Number of prescriptions ^a	4.2	4.4	3.8	5.1	3.7

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy), N/A (not applicable). Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the PDE records by LIS status, monthly LIS eligibility information in Part D's denominator file was used. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Numbers may not sum to totals due to rounding.

^a Number of prescriptions standardized to a 30-day supply.

^b Out-of-pocket (OOP) spending includes all payments that count toward the annual OOP spending threshold.

^c Plan liability includes plan payments for drugs covered by both basic and supplemental (enhanced) benefits.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

- In 2010, gross spending on drugs for the Part D program totaled \$77.7 billion, with roughly three-quarters (\$56.7 billion) accounted for by Medicare beneficiaries enrolled in PDPs. Part D enrollees receiving the LIS accounted for about 56 percent (\$43.3 million) of the total.
- The number of prescriptions filled by Part D enrollees totaled 1.41 billion, with about 67 percent (944 million) accounted for by PDP enrollees. The 38 percent of enrollees who received the LIS accounted for about 45 percent (629 million) of the total number of prescriptions filled.
- Medicare beneficiaries enrolled in Part D plans fill 4.2 prescriptions at \$231 per month on average. PDP enrollees have higher average monthly spending and more prescriptions filled compared with MA–PD plan enrollees.
- The average monthly plan liability for MA–PD enrollees (\$111) is considerably lower than that of PDP enrollees (\$154), while average monthly OOP spending is similar for enrollees in both types of plans (\$37 vs. \$41). The average monthly low-income cost sharing subsidy is much lower for MA–PD enrollees (\$23) compared with PDP enrollees (\$70).
- Average monthly spending per enrollee for an LIS enrollee (\$348) is more than double that of a non-LIS enrollee (\$163), while the average number of prescriptions filled per month by an LIS enrollee is 5.1 compared with 3.7 for a non-LIS enrollee. LIS enrollees have much lower OOP spending, on average, than non-LIS enrollees (\$8 vs. \$59). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging \$142 per month.

Chart 10-17. Part D risk scores vary across regions, by plan type and by LIS status, 2010

PDP region	State(s)	Percent enrolled in PDPs vs. MA-PDs	Percent of Part D enrollees receiving LIS	Average risk score (RxHCC)				
				Part D	PDP	MA-PD	LIS	Non-LIS
All regions				Average absolute risk score				
				1.117	1.137	1.083	1.217	1.055
				Average normalized risk score (mean = 1.0)				
1	ME, NH	85%	49%	0.974	0.971	0.925	0.956	0.962
2	CT, MA, RI, VT	69	43	1.009	1.008	1.001	1.007	0.995
3	NY	55	46	1.029	1.055	1.007	1.015	1.019
4	NJ	81	35	1.036	1.038	0.981	1.032	1.045
5	DE, DC, MD	86	41	1.028	1.016	1.025	1.028	1.021
6	PA, WV	56	33	1.008	1.015	1.008	1.009	1.018
7	VA	78	37	1.000	0.993	0.991	1.003	0.999
8	NC	75	43	1.020	1.017	1.008	1.024	1.004
9	SC	77	45	1.026	1.009	1.058	1.011	1.021
10	GA	69	43	1.027	1.025	1.023	1.018	1.020
11	FL	53	35	1.058	1.067	1.060	1.061	1.062
12	AL, TN	65	47	1.047	1.031	1.076	1.033	1.034
13	MI	73	40	1.016	1.033	0.950	1.030	1.002
14	OH	63	36	1.029	1.042	1.009	1.057	1.018
15	IN, KY	80	39	1.013	1.011	0.987	1.016	1.008
16	WI	63	33	0.954	0.968	0.930	0.991	0.945
17	IL	87	38	0.988	0.981	0.949	0.988	0.988
18	MO	69	35	0.999	1.006	0.975	1.023	0.992
19	AR	80	45	0.997	0.985	1.006	0.973	0.998
20	MS	88	54	1.008	0.993	1.022	0.971	1.006
21	LA	65	49	1.021	1.027	1.007	0.996	1.015
22	TX	69	45	1.035	1.031	1.037	1.026	1.022
23	OK	79	38	0.995	0.990	0.977	0.994	0.995
24	KS	85	29	0.959	0.949	0.950	0.977	0.970
25	IA, MN, MT, NE, ND, SD, WY	73	27	0.910	0.909	0.897	0.949	0.914
26	NM	62	39	0.928	0.917	0.949	0.905	0.942
27	CO	49	29	0.918	0.911	0.938	0.942	0.924
28	AZ	45	32	0.964	0.929	1.011	0.963	0.978
29	NV	48	29	0.963	0.962	0.979	0.967	0.980
30	OR, WA	59	31	0.917	0.910	0.933	0.920	0.929
31	ID, UT	56	28	0.914	0.915	0.921	0.932	0.927
32	CA	51	39	0.953	0.964	0.953	0.939	0.960
33	HI	44	29	0.928	0.919	0.952	0.899	0.959
34	AK	99	62	0.916	0.900	0.935	0.886	0.885
	Mean	64	38	1.000	1.000	1.000	1.000	1.000
	Minimum	44	27	0.910	0.900	0.897	0.886	0.885
	Maximum	99	62	1.058	1.067	1.076	1.061	1.062

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), RxHCC (prescription drug hierarchical condition category). Part D risk scores are calculated by CMS using the RxHCC model developed before 2006. Risk scores shown here are not adjusted for LIS or institutionalized status (multipliers) and are normalized, so that the average across Part D enrollees in each group equals 1.0. If a beneficiary was enrolled in both a PDP and an MA-PD plan during the year, that individual was classified in the type of plan with a greater number of months of enrollment.

Source: MedPAC analysis of Medicare enrollment and Risk Adjustment System files from CMS.

(Chart continued next page)

Chart 10-17. Part D risk scores vary across regions, by plan type and by LIS status, 2010 (continued)

- Under Part D, payments to stand-alone PDPs and MA–PD plans are adjusted to account for differences in enrollees' expected costs using the RxHCC model. The RxHCC model uses age, gender, disability status, and medical diagnosis to predict Part D benefit spending. As is true for any risk-adjustment model, the RxHCC model does not explain all variation in future payments. The model may also produce higher scores in areas with high service use because there are more opportunities to make diagnoses in those areas and the RxHCC model uses diagnoses among other factors in its score.
- In 2010, the normalized average risk scores for Part D enrollees varied from 0.91 (Region 25) to 1.058 (Region 11), meaning that average expected costs per enrollee ranged from about 9 percent below the national average to about 5.8 percent above the national average across regions.
- The overall average risk score for PDP enrollees (1.137) is higher than that of MA–PD enrollees (1.083) and is consistently so across all regions (not shown in table), except in Arizona (Region 28), where most (55 percent) Part D enrollees are enrolled in MA–PDs. In contrast, normalized risk scores for both PDP and MA–PD enrollees are similar in most regions, with the difference exceeding 0.05 (5 percentage points) in only three regions: New Jersey (Region 4), Michigan (Region 13), and Arizona (Region 28).
- The overall average risk score for enrollees receiving the LIS (1.217) is higher than that of non-LIS enrollees (1.055) and is consistently so across all regions (not shown in table). In contrast, normalized risk scores for both LIS and non-LIS enrollees are similar in most regions, with the difference exceeding 0.05 (5 percentage points) only in Hawaii (Region 33), where a relatively small share of enrollees receives the LIS (29 percent).

Chart 10-18. Top 15 therapeutic classes of drugs under Part D, by spending and volume, 2010

Top 15 therapeutic classes by spending			Top 15 therapeutic classes by volume		
	Dollars			Prescriptions	
	Billions	Percent		Millions	Percent
Antihyperlipidemics	\$6.7	8.6%	Antihypertensive therapy agents	145.6	10.4%
Antipsychotics	6.5	8.4	Antihyperlipidemics	136.2	9.7
Diabetic therapy	6.2	8.0	Beta adrenergic blockers	88.9	6.3
Antihypertensive therapy agents	5.1	6.5	Diabetic therapy	88.2	6.3
Asthma/COPD therapy agents	4.9	6.3	Diuretics	77.4	5.5
Peptic ulcer therapy	4.1	5.2	Antidepressants	76.8	5.5
Platelet aggregation inhibitors	3.4	4.4	Peptic ulcer therapy	67.7	4.8
Cognitive disorder therapy (antidementia)	3.2	4.2	Analgesics (narcotic)	67.2	4.8
Antidepressants	3.1	4.0	Calcium channel blockers	60.3	4.3
Analgesics (narcotic)	3.0	3.9	Thyroid therapy	49.5	3.5
Antivirals	2.7	3.5	Antibacterial agents	39.4	2.8
Anticonvulsants	2.2	2.9	Anticonvulsants	38.6	2.7
Analgesics (anti-inflammatory/antipyretic, non-narcotic)	1.8	2.3	Asthma/COPD therapy agents	38.5	2.7
Calcium & bone metabolism regulators	1.7	2.2	Analgesics (anti-inflammatory/antipyretic, non-narcotic)	26.5	1.9
Antibacterial agents	1.5	1.9	Calcium & bone metabolism regulators	25.7	1.8
Subtotal, top 15 classes	56.2	72.4	Subtotal, top 15 classes	1,026.6	73.0
Total, all classes	77.7	100.0	Total, all classes	1,406.0	100.0

Note: COPD (chronic obstructive pulmonary disease). Volume is the number of prescriptions standardized to a 30-day supply. Therapeutic classification based on the First DataBank Enhanced Therapeutic Classification System 1.0. Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- In 2010, gross spending on prescription drugs covered by Part D plans totaled \$77.7 billion. The top 15 therapeutic classes by spending accounted for about 72 percent of the total.
- About 1.4 billion prescriptions were dispensed in 2010, with the top 15 therapeutic classes by volume accounting for 73 percent of the total.
- Eleven therapeutic classes are among the top 15 based on both spending and volume. Central nervous system agents (antipsychotics, anticonvulsants, and antidepressants) and cardiovascular agents (antihyperlipidemics, antihypertensive therapy agents) dominate the list by spending, each accounting for about one-fifth of the spending, while cardiovascular agents (antihyperlipidemics, antihypertensive therapy agents, beta adrenergic blockers, calcium channel blockers, and diuretics) dominate the list by volume, accounting for nearly 50 percent of the prescriptions in the top 15 therapeutic classes.

Chart 10-19. Generic dispensing rate for the top 15 therapeutic classes, by plan type, 2010

By order of aggregate spending	PDP share of all prescriptions	Generic dispensing rate		
		All	PDPs	MA-PDs
Antihyperlipidemics	63%	65%	60%	72%
Antipsychotics	83	38	38	39
Diabetic therapy	64	61	58	66
Antihypertensive therapy agents	63	78	75	81
Asthma/COPD therapy agents	71	9	10	7
Peptic ulcer therapy	68	77	74	85
Platelet aggregation inhibitors	68	8	8	10
Cognitive disorder therapy (antidementia)	74	5	4	6
Antidepressants	71	80	78	85
Analgesics (narcotic)	72	94	93	95
Antivirals	76	38	34	51
Anticonvulsants	75	85	84	87
Analgesics (anti-inflammatory/ antipyretic, non-narcotic)	66	82	80	86
Calcium & bone metabolism regulators	65	63	60	69
Antibacterial agents	69	89	89	91
All therapeutic classes	67	74	72	77

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), COPD (chronic obstructive pulmonary disease). Shares are calculated as a percent of all prescriptions standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System 1.0. Generic dispensing rate is defined as the proportion of generic prescriptions dispensed within a therapeutic class. Part D prescription drug event records are classified as PDP or MA-PD records based on the contract identification on each record.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- In 2010, Part D enrollees in stand-alone PDPs accounted for 67 percent of prescriptions dispensed under Part D. PDP enrollees accounted for a disproportionately high share of prescriptions for classes such as antipsychotics, anticonvulsants, and antivirals. Most of the prescriptions in these classes were taken by low-income subsidy (LIS) beneficiaries, of whom about 80 percent are enrolled in PDPs.
- Overall, analgesics (narcotic) have the highest generic dispensing rate (GDR) (94 percent), followed by antibacterial agents (89 percent) and anticonvulsants (85 percent) compared with 74 percent across all therapeutic classes.
- The GDR for PDP enrollees averages 72 percent across all therapeutic classes, compared with 77 percent for MA-PD plan enrollees. Across the 15 therapeutic classes, GDRs for PDP enrollees were generally lower than for MA-PD enrollees with the exception of agents for asthma/chronic obstructive pulmonary disease therapy.
- There were large differences in GDRs for PDPs and MA-PDs. The largest differences were for antihyperlipidemics, peptic ulcer therapy, and antivirals, with between 11 and 17 percentage point differences. Some of the difference in the GDRs reflects the fact that most beneficiaries receiving the LIS are in PDPs. On average, LIS enrollees are less likely to take a generic medication in a given therapeutic class (see Chart 10-20).

Chart 10-20. Generic dispensing rate for the top 15 therapeutic classes, by LIS status, 2010

By order of aggregate spending	LIS share of prescriptions	Generic dispensing rate		
		All	LIS	Non-LIS
Antihyperlipidemics	35%	65%	59%	67%
Antipsychotics	83	38	37	41
Diabetic therapy	48	61	53	68
Antihypertensive therapy agents	36	78	75	79
Asthma/COPD therapy agents	59	9	11	6
Peptic ulcer therapy	51	77	73	82
Platelet aggregation inhibitors	43	8	7	9
Cognitive disorder therapy (antidementia)	52	5	3	6
Antidepressants	53	80	77	84
Analgesics (narcotic)	59	94	92	95
Antivirals	67	38	24	67
Anticonvulsants	64	85	84	87
Analgesics (anti-inflammatory/antipyretic, non-narcotic)	48	82	82	82
Calcium & bone metabolism regulators	35	63	59	65
Antibacterial agents	44	89	87	91
All therapeutic classes	45	74	71	76

Note: LIS (low-income subsidy), COPD (chronic obstructive pulmonary disease). Shares are calculated as a percent of all prescriptions standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification system 1.0. Generic dispensing rate is defined as the proportion of generic prescriptions dispensed within a therapeutic class. Part D prescription drug event (PDE) records are classified as LIS or non-LIS records based on monthly LIS eligibility information in Part D's denominator file. Estimates are sensitive to the method used to classify PDE records as LIS or non-LIS.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

- In 2010, Part D enrollees receiving the LIS accounted for 45 percent of prescriptions dispensed under Part D. In 10 of 15 therapeutic classes ranked by spending, the share of prescriptions dispensed to LIS beneficiaries was greater than 45 percent, and in 3 classes the share was greater than 60 percent.
- The generic dispensing rate (GDR) for non-LIS beneficiaries averages 76 percent across all therapeutic classes, compared with 71 percent for LIS beneficiaries. Across the top 15 therapeutic classes, GDRs for non-LIS beneficiaries are higher than those for LIS beneficiaries in all but two classes (asthma/chronic obstructive pulmonary disease therapy agents and non-narcotic analgesics).
- There are large differences in GDRs across classes between LIS and non-LIS beneficiaries. The largest difference is for antivirals (45 percentage points). Some of the difference in the GDRs for this therapeutic class likely reflects differences in the mix of drugs taken between the two groups.

Web links. Prescription drugs

- Chapters in several of MedPAC's Reports to the Congress provide information on the Medicare Part D program, as does MedPAC's March 2011 Part D Data Book and Payment Basics series.

http://www.medpac.gov/chapters/Mar12_Ch13.pdf
http://www.medpac.gov/chapters/Mar11_Ch13.pdf
http://www.medpac.gov/chapters/Mar10_Ch05.pdf
http://www.medpac.gov/documents/Mar10_PartDDataBook.pdf
http://www.medpac.gov/chapters/Mar09_Ch04.pdf
http://www.medpac.gov/chapters/Mar08_Ch04.pdf
http://www.medpac.gov/chapters/Mar08_Ch05.pdf
http://www.medpac.gov/chapters/Jun07_Ch07.pdf
http://www.medpac.gov/chapters/Mar07_Ch04.pdf
http://www.medpac.gov/publications/congressional_reports/Jun06_Ch07.pdf
http://www.medpac.gov/publications/congressional_reports/Jun06_Ch08.pdf
http://www.medpac.gov/publications/congressional_reports/June05_ch1.pdf
http://www.medpac.gov/publications/congressional_reports/June04_ch1.pdf
http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_PartD.pdf

- Analysis of Medicare payment systems and follow-on biologics can be found in MedPAC's June 2009 Report to the Congress.

http://www.medpac.gov/chapters/Jun09_Ch05.pdf

- Analysis of Medicare spending on Part B drugs can be found in MedPAC's January 2007 and January 2006 Reports to the Congress.

http://www.medpac.gov/documents/Jan07_PartB_mandated_report.pdf
http://www.medpac.gov/publications/congressional_reports/Jan06_Oncology_mandated_report.pdf

- A series of Kaiser Family Foundation fact sheet data spotlights provide information on the Medicare Part D benefit.

<http://www.kff.org/medicare/rxdrugbenefits/partddataspotlights.cfm>

- CMS information on Part D.

<http://www.cms.gov/PrescriptionDrugCovGenIn/>
<http://www.cms.hhs.gov/MCRAAdvPartDENrolData/>
http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage
http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp

SECTION

11

Other services

Dialysis

Hospice

Clinical laboratory

Chart 11-1. Number of dialysis facilities is growing and share of for-profit and freestanding dialysis providers is increasing

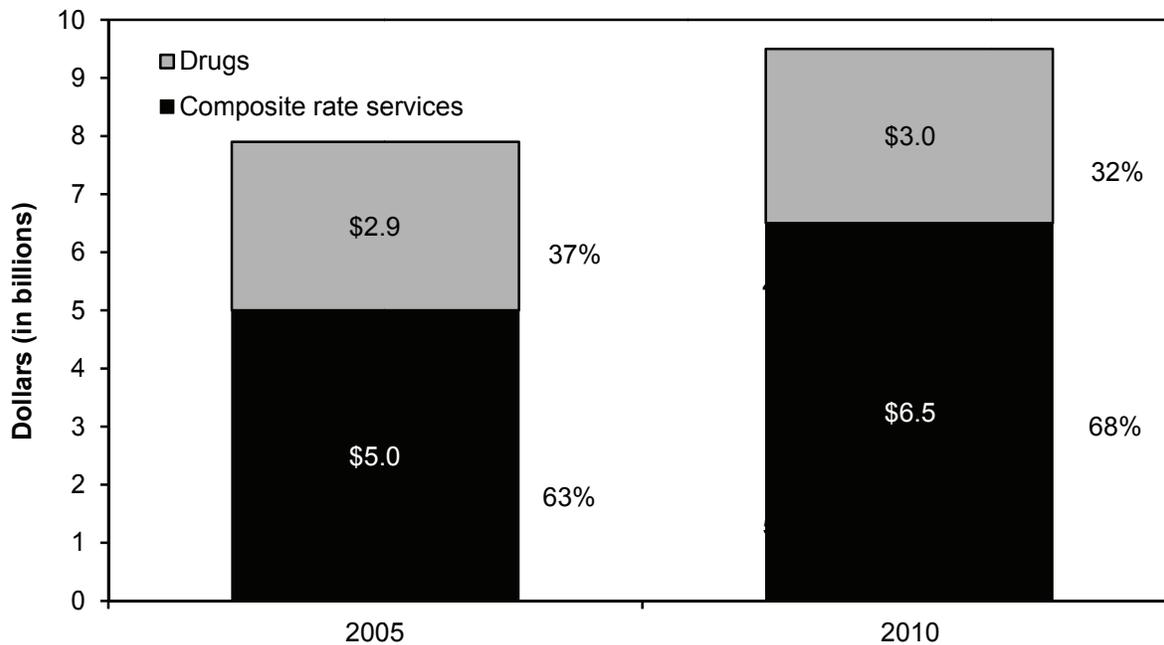
	2011	Average annual percent change	
		2006–2011	2010–2011
Total number of:			
Dialysis facilities	5,560	4%	3%
Hemodialysis stations	98,603	5	4
Mean number of hemodialysis stations per facility	18	0.3	0.5
Hospital based	10	-2	-3
Freestanding	90	5	3
Urban	78	4	3
Rural, micropolitan	14	3	1
Rural, adjacent to urban	5	4	3
Rural, not adjacent to urban	3	4	2
Frontier	1	1	3
For profit	83	5	4
Nonprofit	17	-1	-3

Note: Nonprofit includes facilities designated as either nonprofit or government.

Source: Compiled by MedPAC from the CMS Dialysis Compare file.

- Between 2006 and 2011, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 86 percent to 90 percent of all facilities, and for-profit facilities increased from 79 percent to 83 percent of all facilities.
- Between 2006 and 2011, the proportion of facilities located in rural areas has remained relatively constant.
- The number of facilities has increased 4 percent per year since 2006. The average size of a facility has increased slightly, as evidenced by the mean number of hemodialysis stations per facility, which increased from 17 in 2006 to 18 in 2011.

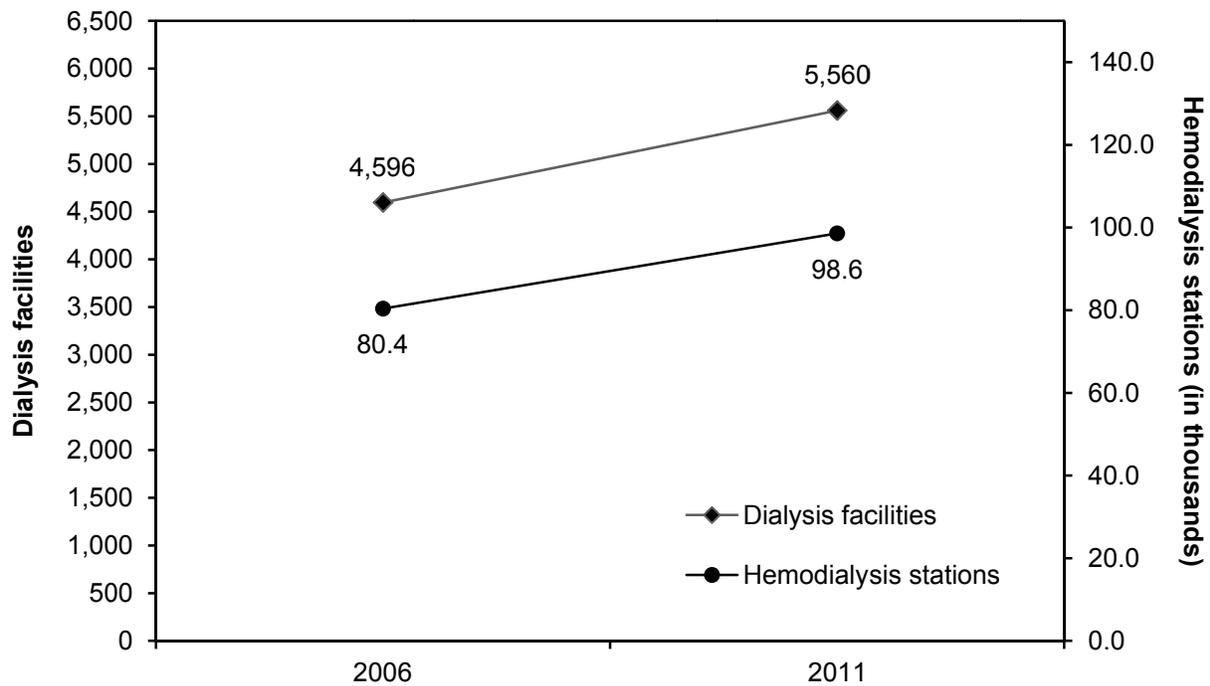
Chart 11-2. Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2005 and 2010



Source: Compiled by MedPAC from the 2005 and 2010 institutional outpatient files from CMS.

- Between 2005 and 2010, total expenditures for composite rate services and dialysis drugs increased by about 4 percent per year. During this time, expenditures for composite rate services increased by 5 percent per year while expenditures for dialysis drugs increased by 0.5 percent per year.
- Freestanding dialysis facilities treat most dialysis beneficiaries and accounted for 88 percent of expenditures in 2005 and 91 percent of expenditures in 2010. Between 2009 (reported in MedPAC's June 2011 Data Book) and 2010, total Medicare expenditures for dialysis services at freestanding dialysis facilities increased by 4 percent to \$8.7 billion.
- The decline in the proportion of spending for dialysis drugs and the increase in the proportion of total dialysis spending for composite rate services is due to statutory and regulatory changes. Beginning in 2005, CMS implemented policies that increased Medicare's payment rate for composite rate services but lowered the rate for dialysis drugs.
- In addition to the change in the drug payment rate, the per capita use of erythropoiesis-stimulating agents, the drug class accounting for three-quarters of dialysis drugs spending, declined between 2009 and 2010. This decline is linked to new clinical evidence about the appropriate use of these drugs. Also, some providers, beginning in 2010, began to phase in new (lower) prescribing protocols for dialysis drugs in anticipation of Medicare's change to a bundled payment method in 2011 that no longer pays separately for these drugs.

Chart 11-3. Dialysis facilities' capacity increased between 2006 and 2011



Source: Compiled by MedPAC from the Dialysis Compare database from CMS.

- Providers have met the demand for furnishing care to an increasing number of dialysis patients by opening new facilities. In 2011, an average facility had about 18 hemodialysis stations.
- Between 2006 and 2011, the total number of dialysis facilities grew by about 4 percent annually, and the number of hemodialysis stations grew by 5 percent annually.

Chart 11-4. Characteristics of Medicare fee-for-service dialysis patients, 2010

	Percent of all FFS dialysis patients
Age (years)	
Under 45	12%
45-64	37
65-74	25
75-84	19
85+	7
Sex	
Male	54
Female	46
Race	
White	51
African American	36
All other	14
Residence	
Urban county	81
Rural county, micropolitan	11
Rural county, adjacent to urban	5
Rural county, not adjacent to urban	3
Frontier county	1
Prescription drug coverage status	
Enrolled in Part D plan	70
Coverage through employers that receive RDS	10
Coverage through other creditable sources	11
No creditable coverage	9
LIS	55*
Medicare as the secondary payer	7*
Dually eligible for Medicaid	47

Note: FFS (fee-for-service). RDS (retiree drug subsidy), LIS (low-income subsidy). Urban counties contain a core area with 50,000 or more population, rural micropolitan counties contain at least one cluster of at least 10,000 and less than 50,000 population, rural counties adjacent to urban areas do not have a city of 10,000 people in the county, and rural counties not adjacent to urban areas do not have a city of 10,000 people. Frontier counties are counties with six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.
*2009 estimates

Source: MedPAC analysis of dialysis claims files and denominator files from CMS.

- Compared with all Medicare patients, FFS dialysis patients are disproportionately younger and African American.
- In 2010, about 20 percent of FFS dialysis patients resided in a rural county.
- Nearly half of all dialysis patients were dually eligible for Medicare and Medicaid services.
- Medicare was the secondary payer (for Part A and Part B) for 7 percent of FFS dialysis patients who were insured by an employer group health plan at the time they are diagnosed with end-stage renal disease.
- About 91 percent of FFS dialysis patients were enrolled in Part D plans or have other sources of creditable drug coverage.

Chart 11-5. The ESRD population is growing, and most ESRD patients undergo dialysis

	1999		2005		2009	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	372.0	100%	487.6	100%	571.4	100%
Dialysis	269.7	73	343.9	71	398.9	70
In-center hemodialysis	240.3	65	314.6	65	365.8	64
Home hemodialysis	2.4	1	2.2	<1	4.5	1
Peritoneal dialysis	25.9	7	26.1	5	27.6	5
Unknown	1.1	<1	0.9	<1	1.0	<1
Functioning graft and kidney transplants	102.4	28	143.7	29	172.6	30

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding. The above data includes both Medicare and non-Medicare patients.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with ESRD require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 4 percent annually between 1999 and 2009.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is usually performed in a patient's home.
- Most ESRD patients undergo hemodialysis administered in dialysis facilities three times a week. Between 1999 and 2009, the total number of in-center hemodialysis patients increased by 4 percent annually while the number of patients using the predominant home modality—peritoneal dialysis—remained about the same. Although only a small proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew 7 percent annually during this time period.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living or a cadaveric kidney donation. In 2009, 36 percent of the kidneys were from living donors and 64 percent were from cadaver donors.

Chart 11-6. Diabetics, middle-aged and the elderly, Asian Americans, and Hispanics are among the fastest growing segments of the ESRD population

	Percent of total in 2009	Average annual percent change 2004–2009
Total (<i>n</i> = 571,414)	100%	4%
Age (years)		
0–19	1	1
20–44	18	1
45–64	45	5
65–79	28	4
80+	9	5
Sex		
Male	57	4
Female	43	4
Race/ethnicity		
White	61	4
African American	32	4
Native American	1	4
Asian American	5	8
Hispanic	15	7
Non-Hispanic	85	4
Underlying cause of ESRD		
Diabetes	38	5
Hypertension	25	4
Glomerulonephritis	15	2
Other causes	23	5

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding. ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among ESRD patients, 37 percent are over age 65. About 61 percent are White.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 4 percent annually between 2004 and 2009. Among the fastest growing groups of patients are those who are between 45 and 64, over age 80, Asian Americans, and Hispanics.

Chart 11-7. Aggregate margins vary by type of freestanding dialysis facility, 2010

Type of facility	Percentage of Medicare payments going to freestanding facilities	Aggregate margin
All facilities	100%	2.3%
Urban	85	3.4
Rural	15	-3.7
LDOs	69	3.4
Non-LDOs	31	0.1

Note: LDO (large dialysis organization). Margins include payments and costs for composite rate services and injectable drugs.

Source: Compiled by MedPAC from 2010 cost reports and the 2010 institutional outpatient file from CMS.

- For 2010, the aggregate Medicare margin for composite rate services and injectable drugs was 2.3 percent.
- As in earlier years, we continue to see higher margins for facilities affiliated with the two largest dialysis organizations. This finding stems from differences in the composite rate cost per treatment and drug payment per treatment. Compared with their counterparts, the composite rate cost per treatment was lower and the drug payment per treatment was higher for the two largest chains.
- In 2010, the gap between the Medicare margins for urban and rural facilities widened because of differences in the volume of drugs furnished across providers. In addition, compared to urban facilities, rural facilities are on average smaller, in terms of the number of treatments they provide, and have higher cost per treatment for composite rate services. The Commission will continue to monitor the adequacy of Medicare's payments for urban and rural facilities in upcoming years. Some rural facilities may benefit from the low-volume adjustment that is included in the new end-stage renal disease payment method that began in 2011.

Chart 11-8. Medicare hospice use and spending grew substantially from 2000 to 2010

	2000	2009	2010	Annual change, 2000–2009	Change, 2009–2010
Beneficiaries in hospice	513,000	1,090,000	1,159,000	8.7%*	6.3%
Medicare payments (in billions)	\$2.9	\$12.1	\$13.0	17.2*	7.2
Average length of stay among decedents (in days)	54	84	86	5.0*	2.1
Median length of stay among decedents (in days)	17	17	18	0 days	1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

*Average annual change.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims Standard Analytic File from CMS.

- The number of Medicare beneficiaries receiving hospice services more than doubled over the last decade and continued to grow in 2010, suggesting that access to hospice care has increased.
- The average length of stay among Medicare decedents who used hospice grew substantially over the decade, from 54 days in 2000 to 86 days in 2010. This growth reflects an increase in length of stay among hospice users with the longest stays while median length of stay has changed little (see Chart 11-12).
- Total Medicare payments to hospices more than quadrupled from 2000 to 2010 due to increased enrollment and longer lengths of stay.

Chart 11-9. Hospice use increased across beneficiary groups from 2000 to 2010

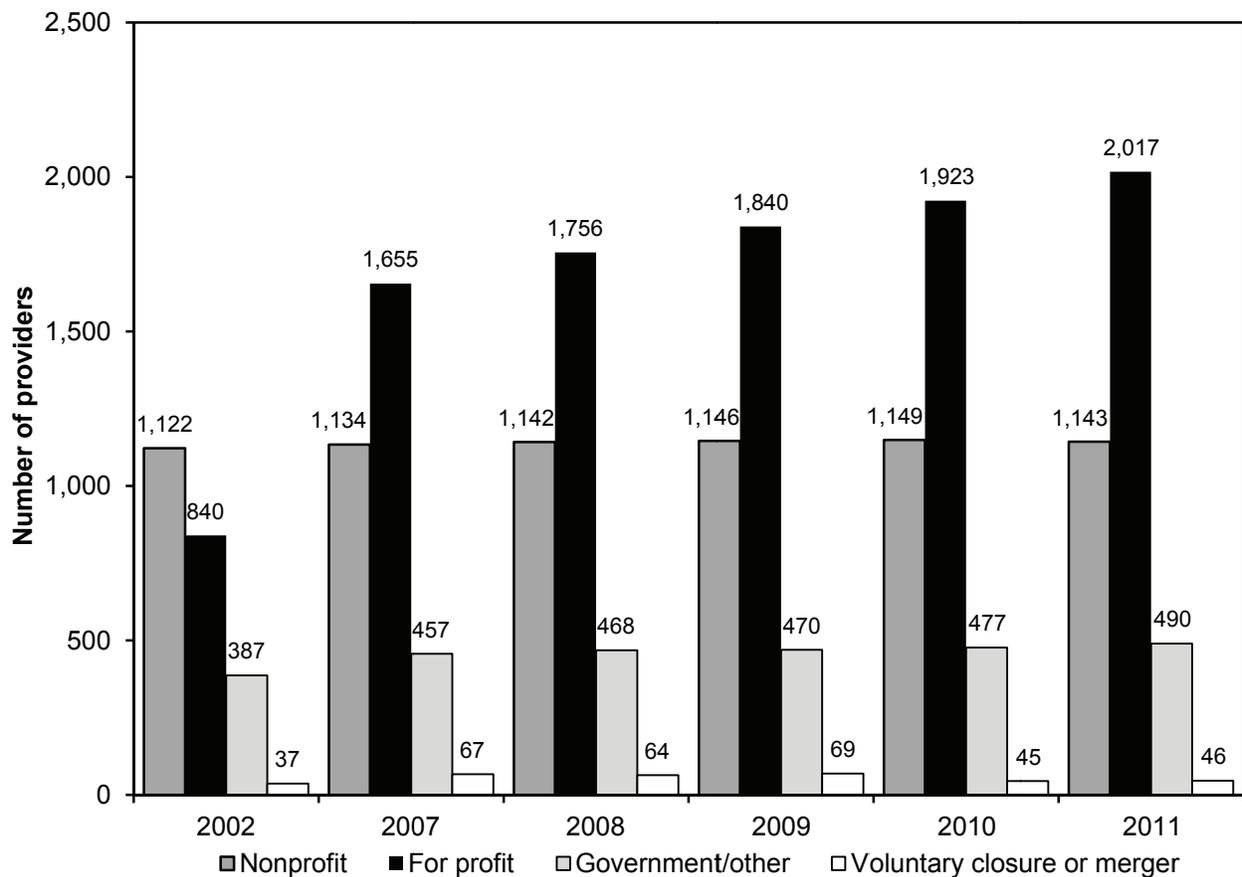
	Percent of decedents using hospice			Average annual percentage point change 2000–2009	Percentage point change 2009–2010
	2000	2009	2010		
All	22.9%	42.0%	44.0%	2.1	2.0
FFS beneficiaries	21.5	41.0	43.0	2.2	2.0
MA beneficiaries	30.9	46.1	47.8	1.7	1.7
Dual eligibles	17.5	37.5	39.2	2.2	1.7
Nondual eligibles	24.5	43.4	45.5	2.1	2.1
Age (years)					
<65	17.0	26.0	27.2	1.0	1.2
65–84	24.7	41.0	42.6	1.8	1.6
85+	21.4	48.0	50.4	3.0	2.4
Race/ethnicity					
White	23.8	43.7	45.8	2.2	2.1
Minority	17.3	32.0	33.6	1.6	1.6
Gender					
Male	22.4	38.6	40.4	1.8	1.8
Female	23.3	45.1	47.1	2.4	2.0
Beneficiary location					
Urban	24.3	43.5	45.4	2.1	1.9
Micropolitan	18.5	37.5	39.8	2.1	2.3
Rural, adjacent to urban	17.6	36.9	38.7	2.1	1.8
Rural, nonadjacent to urban	15.8	32.8	34.5	1.9	1.7
Frontier	13.2	27.1	30.1	1.5	3.0

Note: FFS (fee-for-service), MA (Medicare Advantage). Beneficiary location reflects the beneficiary's county of residence. Urban, micropolitan, and rural designations are based on the urban influence codes. The frontier category is defined as population density equal to or less than 6 persons per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

- Hospice use grew in all beneficiary groups in 2010, continuing a decade long trend of increased hospice use rates.
- Despite this growth, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, MA enrollees, not dual eligible, or lived in an urban area were more likely to use hospice than their counterparts.

Chart 11-10. Number of Medicare-participating hospices has increased, largely driven by for-profit hospices



Source: CMS Providing Data Quickly Query. <https://pdq.cms.hhs.gov/index.jsp>.

- There were more than 3,600 Medicare-participating hospices in 2011. A majority of them were for-profit hospices.
- Between 2002 and 2011, the number of Medicare-participating hospices grew by about 1,300. For-profit hospices accounted for over 90 percent of that growth.
- In 2011, just over 45 hospices voluntarily exited the Medicare program due to a closure or merger, compared with over 60 hospices annually from 2007 to 2009.

Chart 11-11. Hospice cases and length of stay, by diagnosis, 2009

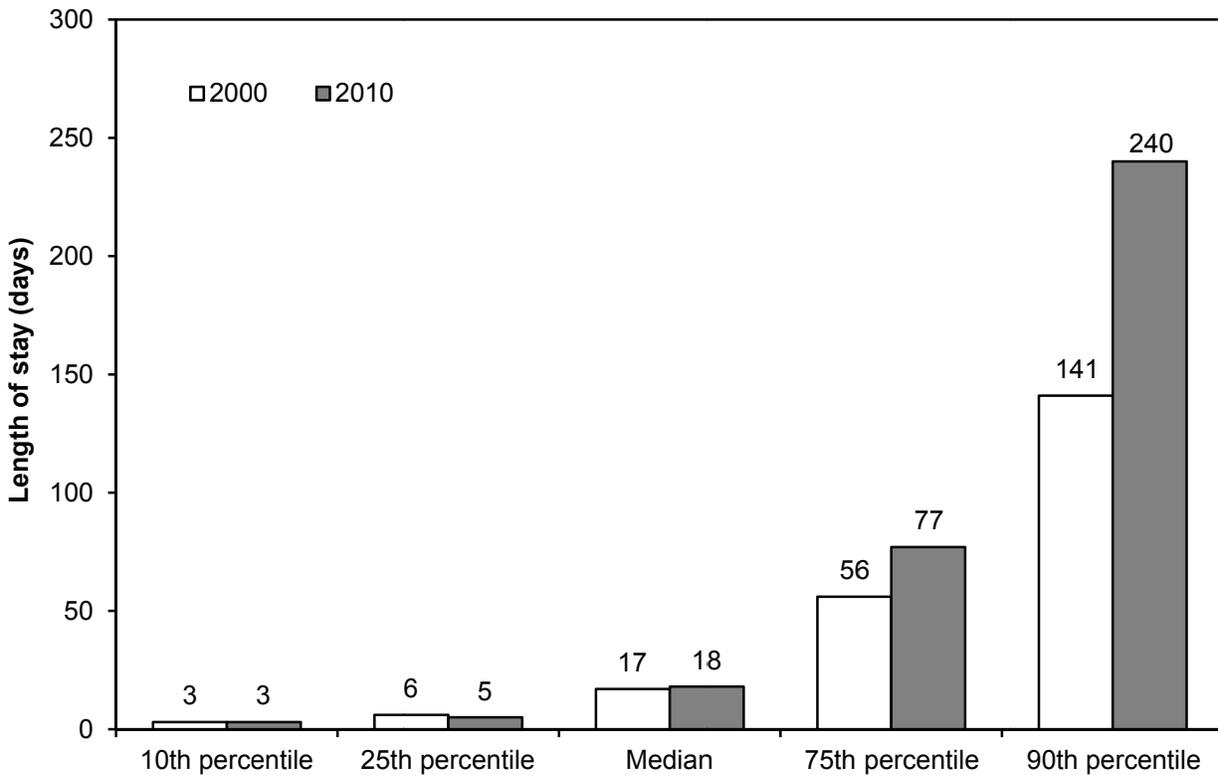
	Diagnosis share of total cases	Percent of cases with length of stay greater than 180 days
Cancer (except lung cancer)	22%	10%
Circulatory, except heart failure	10	19
Debility, NOS	10	25
Lung cancer	9	8
Heart failure	7	21
Unspecific symptoms/signs	6	24
Alzheimer's and similar diseases	6	35
Chronic airway obstruction, NOS	6	26
Dementia	5	30
Organic psychoses	4	29
Respiratory disease	3	11
Genitourinary disease	3	5
Nervous system, except Alzheimer's	3	32
Other	1	11
Digestive disease	1	8
All	100	20

Note: NOS (not otherwise specified). Percent of cases by diagnosis does not sum to 100 due to the exclusion of patients with multiple diagnoses. Share of cases may not sum to figures cited in the text below due to rounding.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytical File from CMS and the Medicare Beneficiary Database.

- In 2009, the most common terminal diagnosis among Medicare hospice patients was cancer, accounting for nearly one-third of cases. The next most common diagnoses were heart failure and other circulatory conditions (18 percent of cases) and Alzheimer's disease, dementia, organic psychoses, and other neurological conditions (17 percent of cases).
- Length of stay varies by diagnosis. At least one-quarter of hospice patients with Alzheimer's disease, dementia, organic psychoses, chronic airway obstruction, and debility had lengths of stay exceeding 180 days. Long hospice stays were least common among beneficiaries with genitourinary disease, digestive disease, and cancer.

Chart 11-12. Long hospice stays are getting longer, while short stays remain virtually unchanged, 2000 and 2010



Note: Data reflect hospice length of stay for Medicare decedents who used hospice at the time of death or before death. Length of stay reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of the denominator file and the Medicare Beneficiary Database from CMS.

- Long hospice stays have grown longer. For example, hospice length of stay at the 90th percentile grew from 141 days in 2000 to 240 days in 2010.
- Short stays in hospice have changed little since 2000. The median length of stay in hospice held steady at 17 or 18 days from 2000 to 2010. Hospice length of stay at the 25th percentile has remained at 5 or 6 days since 2000.

Chart 11-13. Hospice average length of stay among decedents, by beneficiary and hospice characteristics, 2009

	Average length of stay among decedents (in days)
Beneficiary	
Diagnosis	
Cancer	53
Neurological	132
Heart/circulatory	76
Debility	98
COPD	107
Other	85
Site of service	
Home	87
Nursing facility	107
Assisted living facility	143
Hospice facility or hospital	14
Hospice	
For profit	100
Nonprofit	69
Freestanding	87
Home health based	70
Hospital based	62

Note: COPD (chronic obstructive pulmonary disease). Average length of stay is calculated for Medicare beneficiaries who died in 2009 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytical File data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

- Hospice average length of stay varies by both beneficiary and provider characteristics.
- Beneficiaries with neurological conditions, COPD, and debility have the longest average length of stay while beneficiaries with cancer have the shortest stays on average.
- Beneficiaries who receive hospice services in assisted living facilities and nursing facilities have a longer average length of stay than beneficiaries who receive care at home or in a hospice facility or hospital.
- For-profit hospices have a longer average length of stay than nonprofit hospices.
- Freestanding hospices have a longer average length of stay than home health–based or hospital-based hospices.

Chart 11-14. Hospice aggregate Medicare margins, 2003–2009

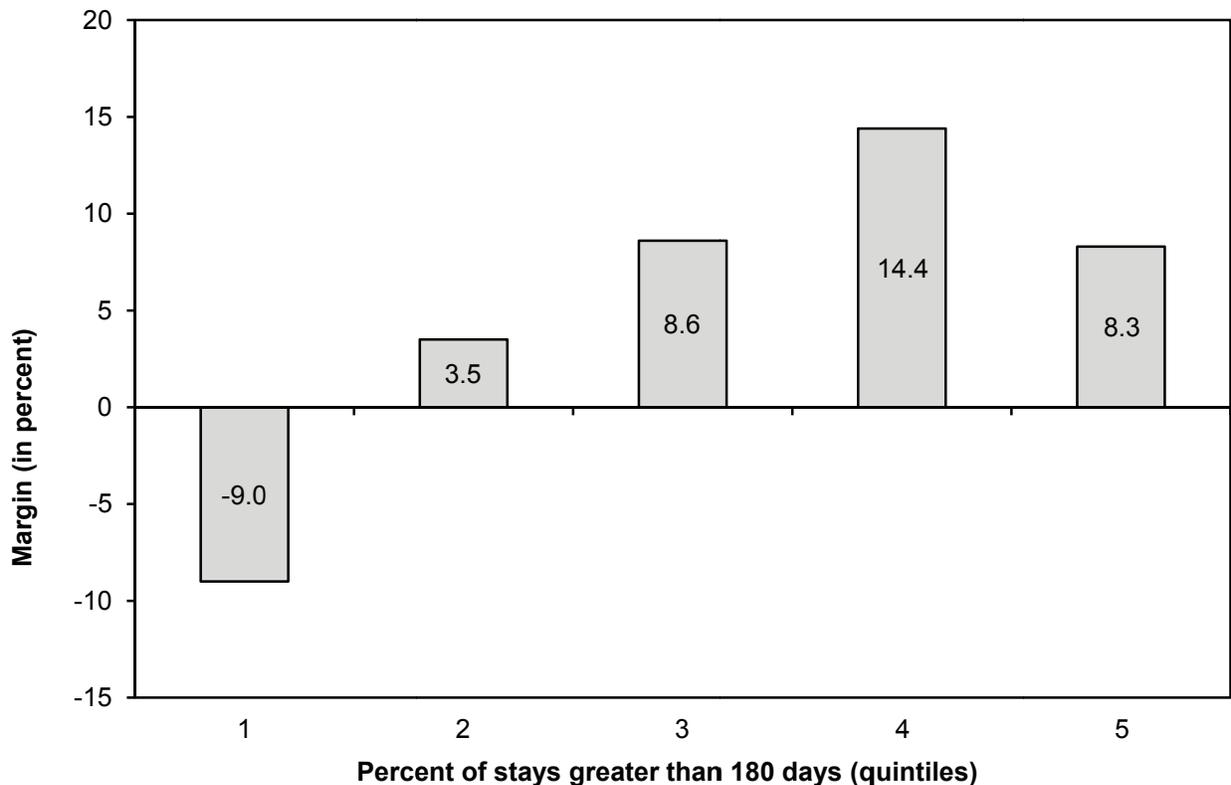
	Percent of hospices (2009)	2003	2006	2007	2008	2009
All	100%	6.6%	6.4%	5.8%	5.1%	7.1%
Freestanding	69	10.9	9.7	8.7	8.0	10.0
Home health based	16	3.9	3.8	2.3	2.7	5.2
Hospital based	15	-14.0	-12.8	-10.7	-12.2	-12.8
For profit	54	15.7	12.0	10.4	10.0	11.4
Nonprofit	33	1.1	1.5	1.7	0.2	3.4
Urban	70	7.4	7.1	6.3	5.6	7.6
Rural	30	0.1	0.8	1.4	1.3	3.1
Below cap	87.5	6.7	7.0	6.1	5.5	7.6
Above cap	12.5	3.5	0.3	2.5	1.0	1.3
Above cap (including cap overpayments)	12.5	23.9	20.7	20.5	19.0	18.3

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. Percent of hospices does not sum to 100 by freestanding/provider-based categories and ownership categories because skilled nursing facility-based hospices and government hospices are not broken out separately.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims Standard Analytic File, and Medicare Provider of Services data from CMS.

- The aggregate Medicare margin was 7.1 percent in 2009, up from 5.1 percent in 2008.
- Margin estimates do not include nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.5 and 0.3 percentage points, respectively). Margins also do not include the costs and revenues associated with fundraising.
- Freestanding hospices had higher margins than provider-based (home health- and hospital-based) hospices, in part due to differences in their indirect costs. Provider-based hospices' indirect costs are higher than those of freestanding providers and are likely inflated due to the allocation of overhead from the parent provider.
- In 2009, for-profit hospice margins were strongly positive at 11.4 percent. The aggregate margin for nonprofit hospices was 3.4 percent. The subset of nonprofit hospices that were freestanding had a higher margin of 6.2 percent (not shown in table).
- Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a margin of more than 18 percent before the return of the cap overpayments.

Chart 11-15. Medicare margins are higher among hospices with more long stays, 2009



Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.

- Medicare’s per-diem-based payment system for hospice provides an incentive for longer lengths of stay.
- Hospices with more long-stay patients generally have higher margins. Hospices in the lowest length-of-stay quintile have a margin of –9.0 percent compared with a 14.4 percent margin for hospices in the second highest length-of-stay quintile.
- Margins are somewhat lower in the highest length-of-stay quintile (8.3 percent) compared with the second highest quintile (14.4 percent) because some hospices in the highest quintile exceeded Medicare’s aggregate payment cap and must repay the overage. Hospices exceeding the cap had a margin of more than 18 percent before the return of overpayments (Chart 11-14).

Chart 11-16. Hospices that exceeded Medicare’s annual payment cap, selected years

	2002	2004	2006	2008*	2009*
Percent of hospices exceeding the cap	2.6%	5.8%	9.4%	10.2%	12.5%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$749	\$731	\$571	\$485
Payments over the cap as a percent of overall Medicare hospice spending	0.6%	1.7%	2.4%	1.7%	1.7%

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year.
 *The estimates for 2008 and 2009 each use a slightly different calculation approach, reflecting changes in the estimation methodology and data availability, and are thus not precisely comparable to earlier years.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File data, Medicare hospice cost reports, Provider of Services file data from CMS, and CMS Providing Data Quickly system. Data on total spending for each fiscal year are from the CMS Office of the Actuary.

- The percent of hospices exceeding Medicare’s aggregate average per beneficiary payment limit, or “cap,” was 12.5 percent in 2009.
- Medicare payments over the cap represented 1.7 percent of total Medicare hospice spending in 2009.
- Our estimates of hospices exceeding the cap are not entirely comparable over time due to refinements to our estimation methodology in 2008 and 2009. On the basis of additional analyses performed with the revised methodology, we believe the percent of hospices exceeding the cap increased each year from 2002 to 2009, while the percent of total payments over the cap and the average amount of the overpayment per above-cap hospice have declined since 2006.

Chart 11-17. Length-of-stay and live discharge rates for above- and below-cap hospices, 2009

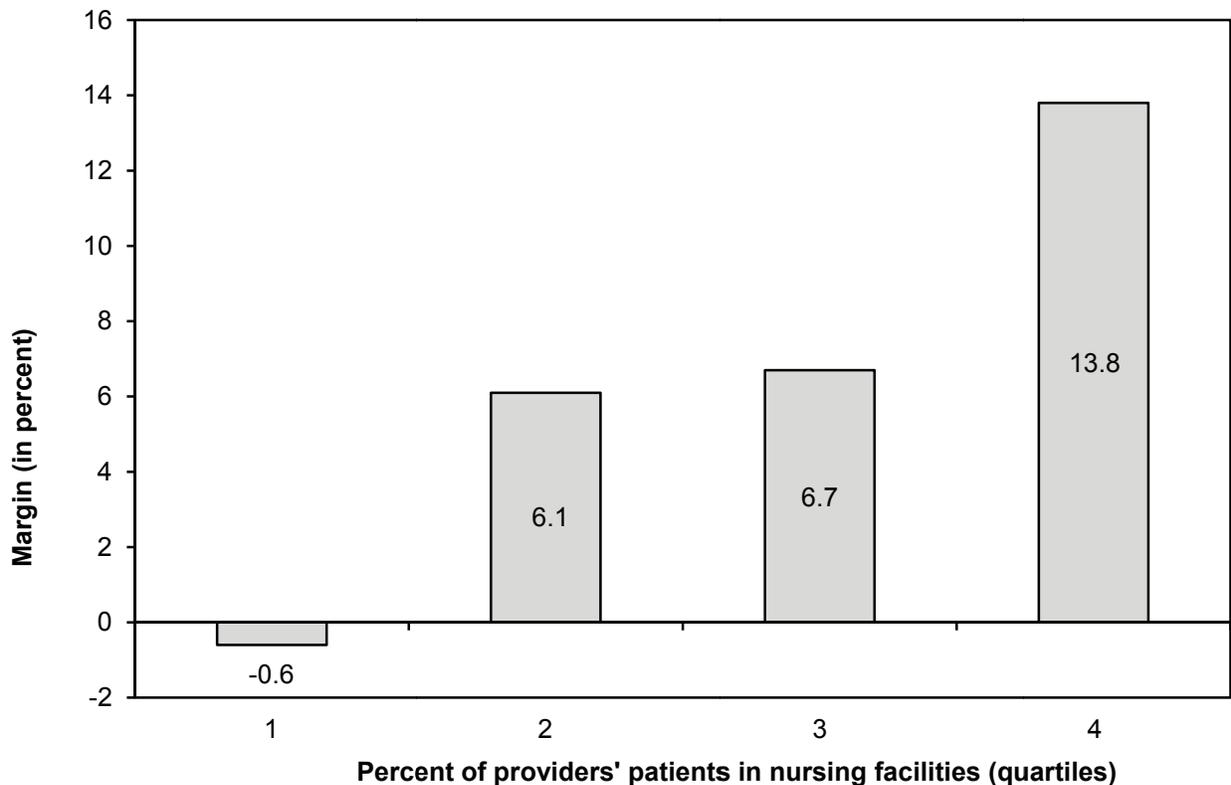
Diagnosis	Percent of hospice users with stays exceeding 180 days		Live discharges as a percent of all discharges	
	Above-cap hospices	Below-cap hospices	Above-cap hospices	Below-cap hospices
All	42%	19%	44%	16%
Cancer	17	9	21	10
Neurological conditions	50	30	35	17
Heart/circulatory	44	18	48	14
Debility	43	23	49	20
COPD	46	25	51	20
Other	49	23	57	25

Note: COPD (chronic obstructive pulmonary disease). Length-of-stay data reflect the percent of hospice users in 2009 whose hospice length of stay was beyond 180 days.

Source: MedPAC analysis of 100 percent hospice claims Standard Analytic File and denominator file from CMS.

- Above-cap hospices have substantially more patients with very long stays and more live discharges than below-cap hospices for all diagnoses.
- Between 43 percent and 50 percent of above-cap hospices' patients with neurological conditions, heart or circulatory conditions, chronic obstructive pulmonary disease, or debility had stays exceeding 180 days compared with 18 percent to 30 percent at below-cap hospices.
- For all diagnoses, the live discharge rates at above-cap hospices were at least double and, in some cases, more than triple the rates at below-cap hospices. For example, among patients with heart or circulatory conditions, 48 percent of discharges at above-cap hospices were live discharges compared with 14 percent at below-cap hospices.

Chart 11-18. Margins are higher among hospices with a greater share of their patients in nursing facilities, 2009

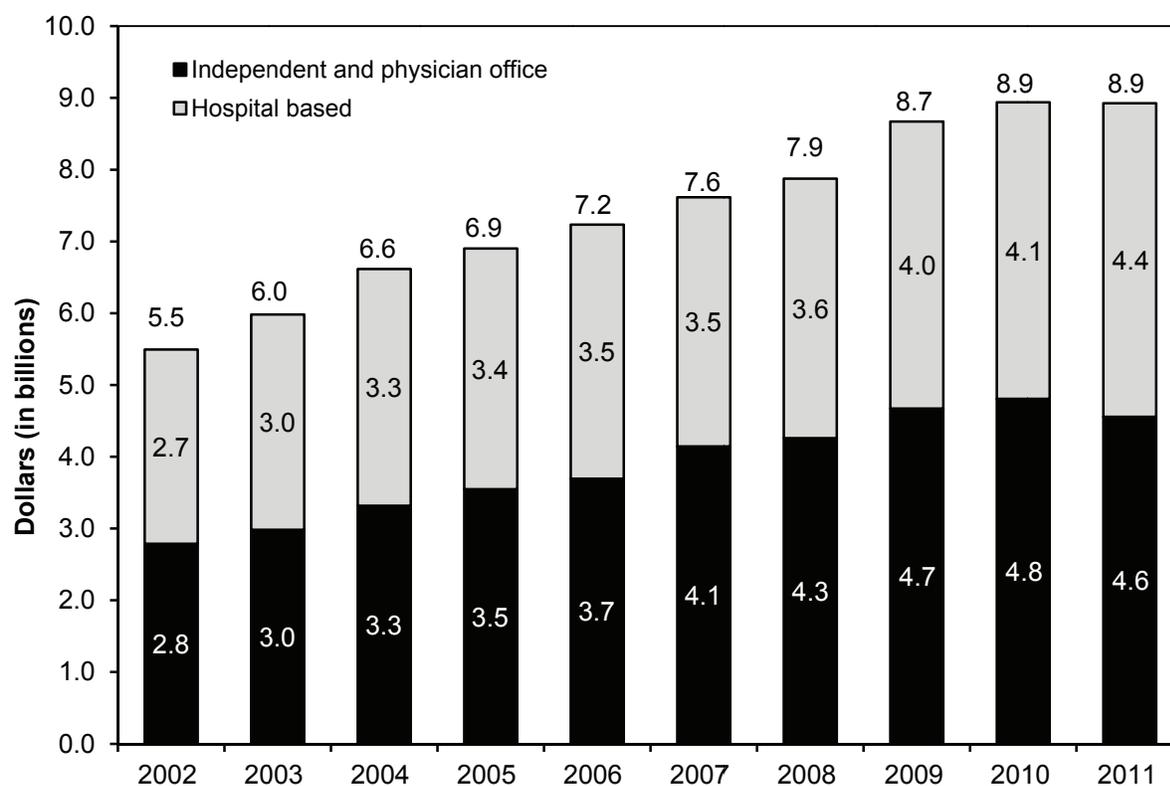


Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.

- Hospices with a large share of their patients in nursing facilities have higher margins than other hospices.
- The higher profitability of hospices serving many nursing facility patients may be due to a combination of factors, such as longer lengths of stay, efficiencies in treating patients in a centralized location (e.g., less mileage costs and staff time for travel), and savings from an overlap in supplies, equipment, and services provided by the hospice and nursing facility.

Chart 11-19. Medicare spending for clinical laboratory services, 2002–2011



Note: Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services are furnished in labs owned or operated by hospitals. Total spending appears on top of each bar. The segments of each bar may not sum to the totals on top of each bar due to rounding. The spending data are calendar year figures from the 2012 annual report of the Medicare Trustees. In data books from prior years, we presented fiscal year data prepared by the CMS Office of the Actuary for the President's Budget request.

Source: 2012 annual report of the Boards of Trustees of the Medicare Trust Funds.

- Medicare spending for clinical laboratory services grew by an average of 5.5 percent per year between 2002 and 2011. This growth was primarily driven by rising volume, as there were only two increases in lab payment rates during those years (1.1 percent in 2003 and 4.5 percent in 2009).
- Spending increased by 10.1 percent in 2009 and 3.1 percent in 2010. Spending was flat in 2011 because a 1.75 percent reduction in payment rates offset increased volume. Clinical lab services accounted for 1.6 percent of total program spending in 2011.
- Hospital-based labs' share of total clinical lab spending increased from 46 percent in 2010 to 49 percent in 2011.

Web links. Other services

Dialysis

- More information on Medicare's payment system for outpatient dialysis services can be found in MedPAC's Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_dialysis.pdf

- The U.S. Renal Data System provides information about the incidence and prevalence of patients with renal disease, their demographic and clinical characteristics, and their spending patterns.

<http://www.usrds.org>

- The National Institute of Diabetes and Digestive and Kidney Diseases provides health information about kidney disease for consumers.

<http://www2.niddk.nih.gov/>

- CMS provides specific information about each dialysis facility.

<http://www.medicare.gov/Dialysis/Home.asp>

- Chapter 6 of the MedPAC March 2012 Report to the Congress provides information about the financial performance of dialysis facilities.

http://www.medpac.gov/chapters/Mar12_Ch06.pdf

- MedPAC's June 2005 Report to the Congress recommends changes to how Medicare pays for composite rate services and injectable drugs.

http://www.medpac.gov/publications%5Ccongressional_reports%5CJune05_ch4.pdf

- MedPAC's October 2003 report describes how Medicare could modernize the outpatient dialysis payment system.

http://www.medpac.gov/publications/congressional_reports/oct2003_Dialysis.pdf

- MedPAC's comment on revisions to payment policies under the physician fee schedule for calendar year 2004 includes changes in how to pay for services furnished by nephrologists.

http://www.medpac.gov/documents/100603_RevPhysFeeSched_CB_comment.pdf

- MedPAC commented on CMS's proposed rule to implement provisions of the Medicare Improvements for Patients and Providers Act of 2008 that modernize the outpatient dialysis payment system by broadening the payment bundle in 2011 and implementing a quality incentive program in 2012.

<http://www.medpac.gov/documents/End%20Stage%20Renal%20Disease.pdf>

Hospice

- More information on Medicare's payment system for hospice services can be found in MedPAC's Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_hospice.pdf

- Additional information and analysis related to the Medicare hospice benefit and the financial performance of hospice providers can be found in Chapter 11 of MedPAC's March 2012 Report to the Congress.

http://www.medpac.gov/chapters/Mar12_Ch11.pdf

- Additional analyses of Medicare hospice visit patterns can be found in the online appendix to the hospice chapters in the March 2011 and March 2010 Report to the Congress.

http://www.medpac.gov/chapters/Mar11_Ch11_APPENDIX.pdf

http://www.medpac.gov/chapters/Mar10_Ch02E_APPENDIX.pdf

- Recommendations for reforms to the hospice payment system and steps to improve accountability and oversight of the benefit can be found in Chapter 6 of MedPAC's June 2009 Report to the Congress.

http://www.medpac.gov/chapters/Mar09_ch06.pdf

- CMS maintains a variety of information related to the hospice benefit.

<http://www.cms.gov/Center/Provider-Type/Hospice-Center.html>

- CMS also provides information on hospice for its beneficiaries.

<http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf>

Clinical laboratory

- More information on Medicare's payment system for clinical lab services can be found in MedPAC's Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_clinical_lab.pdf

- Information about CMS's regulation of clinical laboratories, including the number and type of certified labs in the United States, can be found on the CMS website.

<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>



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